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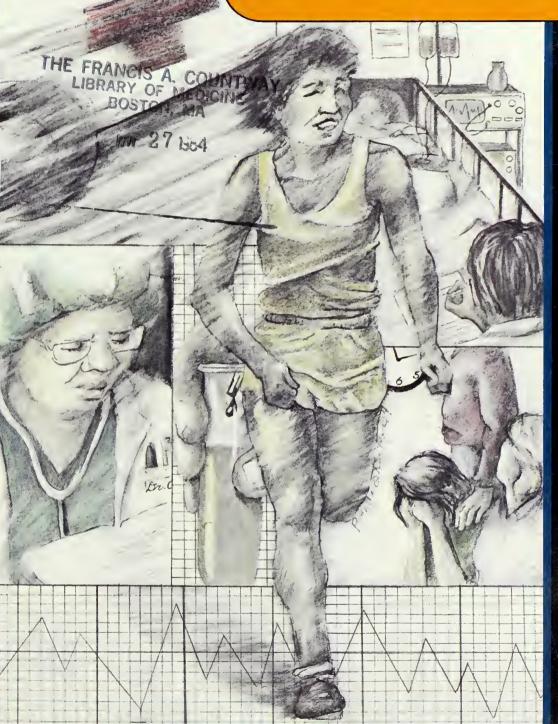
INDIANA MEDICINE



The Journal of the Indiana State Medical Association

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## **ABOUT THE COVER**



Illustration depicts various aspects involved in determining a patient's prognosis following an emergency hospitalization. An article beginning on page 520 examines several statistical rating methods that have been developed to evaluate patients requiring critical care.—Drawing by Brenda Kester, Medical Illustrator, Methodist Hospital of Indiana

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## MEDICAL MUSEUM NOTES

CHARLES A. BONSETT, M.D., Indianapolis



NDIANA STATE MEDICAL Association members, who voluntarily contribute to the Indiana Medical History Society, on occasion of paying the annual ISMA dues, are thereby members of the Society. Since this includes the majority of ISMA members, this month's page of NOTES will be used to give an account of the Society's activities for the year 1983.

## **Financial**

In May 1983 the Museum's assets were placed in a constantly managed trust fund at American Fletcher National Bank of Indianapolis; and at the end of the year an audit was done by Peat, Marwick, and Mitchell. The results of this audit show the total revenue for 1983 was \$19,441 (or \$40,491 if the gain on the sale of certain investments is included). The total expenses were \$16,799. The primary sources of revenue were interest from the Priscilla Brown bequest (NOTES: January 1982), and contributions from the Indiana State Medical Association (\$5,608). Additional contributions were received from the Marion County Medical Society Auxiliary, Ivy Tech Foundation, and from Larry Hitchcock, M.D. Assets for the year, including cash, cash investments, marketable securities, and other assets, totaled \$166,792.

(The 1984 ISMA contribution to date is slightly under \$10,000).

## Collection Development and Management

Nineteen separate gifts, totaling 295 artifacts, were accessioned into the Museum's collection in 1983. Some of the more interesting artifacts donated included a late 19th century pocket microscope, an early pair of 20th century obstetrical forceps, a 1902 diploma from the Fort Wayne Medical School, a ceramic invalid feeder, a mid-19th century spring lancet, a collection of 78 obstetrical and surgical instruments from the late 19th century, and a framed autographed photo of Dr. Theodore



Museum amphitheater, circa 1969, prior to restoration.

Billroth, founder of gastric surgery.

The process of cataloging the objects in the Museum has progressed slowly. The majority of the 295 artifacts accepted into the collection in 1983 were completely catalogued by the end of the year. Of the artifacts in the Museum's existing collection, 89 prints, photographs, and medical artifacts were catalogued in 1983. Helen Davidson, the Museum's volunteer curatorial assistant, who put in 448 hours during 1983, was primarily responsible for the cataloging of these 89 objects. In August 1983 Mrs. Davidson's work and service to the Museum was recognized by presenting her with an engraved plaque.

A significant achievement in the area of collection management and development was the preparation of a guide for cataloging and classifying the collection of medical artifacts at the Museum. This 72-page guide provides the detailed steps and rules for cataloging objects, and a special classification system for objects of a medical history nature.

Another significant step in the area of collection development and management was the renovation of the area under the amphitheater for the storage of objects. The entire area was painted, and special steel shelving with protective plastic

draping installed. Special plastic storage boxes were also purchased, so that a safe, dust-free environment could be provided for the Museum's artifacts.

## **Educational Programs**

The total attendance at the Museum for the year was 435. Guests included the Indiana University School of Medicine, Class of 1933; the Osler Club (St. Vincent Hospital); Ben Davis church retirees; and classes from Capital City Christian School, the Health Care Institute of Indianapolis, Ivy Tech Foundation, Green Castle High School, IUPUI School of Nursing, and DePauw School of Nursing.

Although the Museum offered no special programs for the year, the organization began planning for future programs and exhibits. The Garden Club of Indianapolis was contacted, and their help enlisted for the planting and opening of a medicinal herb garden at the Museum in 1984. The Museum also worked with the Indiana Historical Society to plan an Exhibit on Pre-Civil War Medicine, which opened at the Indiana Historical Society in March 1984. Moreover, in October 1983 the Board approved the publication of a joint lndiana Historical Society-Indiana Medical History Museum Newsletter to be sent to members of the Indiana Historical Society and the Indiana Medical History Society. Also, the Board approved printing a brochure in 1984.

## Publicity

In 1983 articles about the Museum appeared in a February issue of the *Indianapolis Star*; the January issue, Association of Indiana Museums' Bulletin; and the May issue, Newsletter of the American Association for the History of Medicine. Also, a very nice segment about the Museum appeared on Channel 20's Prime Time Indiana.

(The above has been condensed from the annual report of the Indiana Medical History Society, prepared by Katherine McDonell, Curator.)



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## WHAT'S NEW?

Mallinckrodt has a new blood chemistry analyzer for determining potassium values. Named the Serometer®, the instrument is a reagent test and may be operated in a physician's office with accurate results obtained in about 30 minutes.

Schering has a new creamy lotion form of Lotrimin. Lotrimin Lotion 1%, brand of clotrimazole, is the latest addition to the Lotrimin line. It is recommended as a prescription product for use in treating certain superficial fungal infections of the skin.

Overworld Industries is offering Dental Flossers for fast, easy and convenient teeth flossing. The Flosser consists of a plastic handle open at one end in the shape of a U with a short strip of dental floss stretched across the opening. The handle may be bent in any angle for easy access to various teeth. The Dental Flosser is not recommended for routine at-home flossing but rather for convenience when away from home. The Flossers may be carried in a pocketbook, briefcase, traveling bag or lunch box.

Gaymar sells a new sof.care O.R. cushion which employs the capability of configuring to individual patient body shapes and provides surgical patients with highly effective protection against pressure ulcers. It is designed for patients during surgical procedures lasting two or more hours. It is also suited for continued postoperative protection in ICUs and recovery rooms.

Key Pharmaceuticals has FDA approval to indicate dosage information on a transdermal nitroglycerin product in both surface area as measured in square centimeters and in milligrams. Advantages accrue to emergency room physicians and to physicians who are consulted during the patient's travels.

Hewlett-Packard has a new fetal monitor for antepartum screening. The HP 8041A provides an increased level of operational ease and precision to the prelabor examinations of the mother-to-be patient. It carries a low cost and is suitable for use in the office, clinic and hospital.

A battery-powered system that adds mobility and fingertip control to manually operated carts carrying from 500 to 1,000 pounds of medical diagnostic equipment has been developed by Saga Engineering Corporation for hospitals, mobile medical vans, trauma centers and medical clinics. The system is called Medi-Mover I. It may be installed in less than an hour without making structural of electrical modifications to the manual push carts.

**Upjohn** will soon have Micronase Tablets (glyburide) on the market. It is a new, once a day, anti-diabetes medication suitable for treatment of non-insulin-dependent diabetes. Micronase Tablets are not indicated for patients with insulin-dependent diabetes.

Abbott Laboratories has developed a new micro-infusion pump capable of delivering parenteral and enteral fluids in dosages as low as 0.1 milliliters per hour. The "LifeCare Micro Pump" is designed for use with neonates, pediatric patients and fluid-restricted critical care patients. The range of flow extends from 0.1 to 99.9 ml per hour.

Syntex has received FDA approval to market a triphasic oral contraceptive that contains the lowest dose in overall hormonal content currently available. Tri-Norinyl<sup>TM</sup> reduces the incidence of breakthrough bleeding and spotting between periods. The dosage of ethinyl estradiol is constant throughout the cycle. The dosage of the progestational agent (nore-thindrone) increases during the nine days of the cycle when breakthrough bleeding is most likely to occur. Tri-Norinyl is packaged and labeled according to days of the week. It is available in either a 28-day or 21-day regimen.

News of what is new in the medical supply industry is composed of abstracts from news releases by book publishers and manufacturers of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by INDIANA MEDICINE or by the Indiana State Medical Association.

Reflotron is a new blood analyzer for physicians' offices which is manufactured by the Bio-Dynamics Division of Boehringer Mannheim Diagnostics. It is a stand-alone unit, about the size of a portable typewriter. It utilizes dry chemistry technology and modern microelectronics to perform the most frequently requested laboratory tests from a small sample of blood, giving results within minutes.

Intravenous Calan® (verapamil HCl) is now available from Searle in easier-to-use vials, a form that is faster and more convenient for hospital staffs to use than previously available all-glass ampuls. The new vial is stoppered with rubber and protected by a flip-top plastic cap.

Polaroid has two types of film especially adaptable to the production of one-minute black & white or full color films for medical illustrations and projection. The 35mm film may be used in a standard 35mm camera. The Auto-Films are used in the Polaroid Model CB-33 Auto-Film camera. The exposed film is processed and mounted in minutes without darkroom, expensive equipment or precise temperature control.

Western Enterprises has a newly designed, innovative and easy-to-operate line of portable oxygen systems under the Free'n-Easy product name. There are 15 different models, including Free'n-Easy Shoulder Packs, Cartable Packs and a basic Homecare Kit. All are characterized by controls which are easily operated, even by patients who are infirm.

Instromedix has the first micro-holter for ambulatory ECG monitoring. Its name is Instant Replay. It is pocket-sized and easily carried. When a symptom is felt the patient activates the "Record" button. The event is stored and may be transmitted transtelephonically to an Instromedix LifeSigns Receiving Center.

**Amko** offers a new matte black Teflon-coated SRT vaginal speculum which evacuates smoke and induces better field visualization in laser surgery. It is non-reflective, self-lubricating and easy to clean.

## FUTURE FILE

## **Oncology Nursing**

"Oncology Nursing Conference V1" will be sponsored by the Department of Nursing at the University of Texas M. D. Anderson Hospital and Tumor Institute at Houston Sept. 12 to 14 at the Hyatt Regency Hotel Downtown.

Write or phone Office of Conference Services, Box 131, M.D. Anderson Hospital, 6723 Bertner Ave., Houston 77030—(713) 792-2222.

## Lung Cancer 1984

"Lung Cancer 1984" is the topic of the 27th annual Clinical Conference to be held in Houston at the Shamrock Hilton Hotel Nov. 7-9.

Contact Office of Conference Services, Box 131, M.D. Anderson Hospital, 6723 Bertner Ave., Houston 77030—(713) 792-2222.

## Indiana University CME

## For the Primary Care Physician

Aug. 17—Office Orthopedics, 1nn of the Fourwinds, Bloomington.

"Mini-Fellowship in Rheumatology," offered by the Rheumatology Division, Dept. of Medicine, I.U. School of Medicine. For general internists, family physicians and general practitioners. 40-hour instructional program in the I.U. Medical Center; 5 consecutive days, or other suitable arrangements. This program should assist the participant in attaining the skills for effective office management of common rheumatologic problems, interpretation of relevant laboratory tests and techniques for joint aspiration and local soft tissue injection. This will include experience with the "team approach" to management of the arthritic patient in the community. Contact K. Brandt, M.D., Head, Rheumatology Division, 1.U. School of Medicine, (317) 264-4225.

### For the Specialist

Aug. 10, 11—Inflammatory Disease of the Bowel, Hyatt Regency, Indianapolis.

For additional information, contact the CME Division, Indiana University School of Medicine—(317) 264-8353.

## **Cancer Rehabilitation**

The second Fall Cancer Rehabilitation Conference of the University of Wisconsin will be conducted Oct. 4-5 at the University of Wisconsin Hospital in Madison. The fee is \$70.

Contact Sarah Aslakson, 465B WARF Bldg., 610 Walnut St., Madison, Wisc. 53705—(608) 263-2856.

## Seminars in Pediatrics

"Seminars in Pediatrics" will be conducted Oct. 12-13 at the Clinical Science Center, University of Wisconsin at Madison.

AMA Category I credit is 10 hours. Fees are \$100 for physicians, \$65 for nurses

Contact Sarah Aslakson, 465B WARF Bldg., 610 Walnut, Madison, Wisc. 53705—(608) 263-2856.

## **ASIM Annual Meeting**

The American Society of Internal Medicine will hold its annual meeting Sept. 20-23 at the Hilton Palacio Del Rio Hotel in San Antonio.

The theme of the meeting will be "Transitions and Transactions." Program sessions will focus on "Medicine, Society and the Dying Patient: The Case of Granny Doe" and "The New Era of Negotiations."

## Lung Cancer

"Lung Cancer" will be the subject of the Cincinnati Cancer Conference III, to be held Nov. 2-3 at the Hyatt Regency in Cincinnati.

For details contact Thomas J. O'Connor, Bethesda Hospitals, 619 Oak St., Cincinnati 45206—(513) 569-6337.

The Journal of the American Medical Association publishes a list of CME courses for the United States twice yearly. The January listing features courses offered from March through August; the July listing features courses offered from September through February.

## Regional Anesthesia

Wayne State University School of Medicine will conduct a course in "Regional Anesthesia: Anatomy and Techniques" at the Detroit Medical Center Aug. 18-19. Registration fee is \$275.

For a copy of the program and other details, write to Wayne State University School of Medicine, CME Division, 4H DRHUHC, 4201 St. Antoine, Detroit 48201.

## **Clinical Nutrition**

"Challenges for Clinical Nutrition in the Eighties" is the title of a postgraduate course to be conducted Sept. 10-11 by the American Society for Parenteral and Enteral Nutrition at the Marriott Pavillion Hotel in St. Louis,

Contact ASPEN, 1025 Vermont Ave., N.W., Suite 810, Washington, D.C. 20005—(202) 638-5881.

## **Pediatrics Symposium**

The 12th annual Fall Pediatric Surgery/Pediatrics Symposium concerning "Care of the Seriously Ill Child" will be held at the Indianapolis Radisson Hotel, Keystone at the Crossing, Oct. 10-11. The symposium will be sponsored by the Indiana University School of Medicine.

Contact Jay Grosfeld, M.D., Riley Hospital, 702 Barnhill Drive, 1ndianapolis 46223—(317) 264-4681, or Joni Downs—(317) 264-8353.

## **Newborn Symposium**

"Cardio-Respiratory Problems in the Newborn" will be the theme of the 18th Annual Newborn Symposium to be conducted by the Pediatrics Department of the University of Louisville School of Medicine Nov. I-2. Category I credits will be allowed.

Contact Billy F. Andrews, M.D., Kosair-Children's Hospital, University of Louisville, Louisville 40292—(502) 562-8826.

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Clinical Oncology Center Methodist Hospital of Indiana, Inc. New information from Indiana Division American Cancer Society, Inc. 4755 Kingsway Dr., Sulte 100 Indianapolis 46205

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## CAUCER CORNER

## 'Camp Friendship' for Children

The Ohio Division will conduct a 4½-day camping program designed specifically for children with cancer, now titled "Camp Friendship." The camp will be held at Camp Kern, Dayton YMCA Camp, located near Kings Island, Aug. 11-15. Attendance will be limited to 40 children, ages 7-15. They will accept eligible children from outside of Ohio. There is no charge.

Interested parents should contact the Ohio Division at 1375 Euclid Ave., Room 312, Cleveland 44115—(216) 771-6700.

## Orientation Kit

An ACS orientation kit has been developed for physicians and dentists who are settling in local communities throughout our state. Sample kits are available through your local Staff Representative. The Welcome Doctor Folder and material contents should be ordered separately from the Division Office Distribution Department.

The kit includes 10 items: I Advise My Patients Not to Smoke and/or Thank You for Not Smoking tent sign; standard breast self-examination brochure; Cancer Chemotherapeutic Agents; The ACS-A Fact Book for the Medical and Related Professions; Cancer Statistics 1984; 1984 Cancer Facts and Figures; Indiana Division Professional Education Materials Catalog; You're Not Alone When Cancer Strikes ("We Can Help"), Indiana Division service brochure; material order form; and program order form.

## **ACS Nutrition Guidelines**

- A healthy, sensible diet may help reduce your chance of getting cancer.
- While no concrete dietary advice can be given that will guarantee prevention of any specific human cancer, some food constituents may cause or promote cancer while others may protect against the disease.
- The National Board of Directors approved the following nutrition guidelines:
   Avoid obesity. The first Cancer

Prevention Study uncovered higher cancer risks for overweight men and women, particularly those 40% or more overweight.

Cut down on total fat intake. Moderation in the use of fatty foods reduces the chances of getting breast, colon and prostate cancers and reduces daily calorie consumption.

Eat more high fiber foods, such as fruits, vegetables and whole grain cereals. Scientists still are debating the possible advantages of the fiber in the diet but even if fiber itself does not prove to have a protective effect against cancer, high-fiber foods are a healthy substitute for fatty foods.

Include foods rich in vitamins A and C in the daily diet. Obtain vitamins from fruits and vegetables. Excessive supplementary use of vitamin A in capsule or tablet form can be toxic.

Include cruciferous vegetables such as cabbage, broccoli, Brussels sprouts, kohlrabi and cauliflower in the diet. Epidemiologic research suggests these foods may help reduce the risk of cancers of the gastrointestinal and respiratory tracts. Animal studies indicate these vegetables may be highly effective in the prevention of chemically induced cancer.

Be moderate in consumption of alcoholic beverages. Heavy drinkers, especially those who also smoke, are at unusually high risk for cancers of the oral cavity, larynx and esophagus. Alcohol abuse also can result in cirrhosis, which sometimes leads to liver cancer.

Be moderate in consumption of saltcured, smoked and nitrite-cured foods. Hams, fish and some sauages smoked by traditional methods absorb cancercausing tars similar to those contained in tobacco smoke. Inferential evidence from around the world links salt-cured or pickled foods to an increased risk of stomach and esophageal cancer.

## **Lung Cancer Exceeds Breast Cancer** in 12 States

At the recent Science Writers Seminar Dr. Gerald P. Murphy, president of the

Society, reported that in at least 12 states lung cancer has surpassed breast cancer as the leading cause of female cancer death. A list of these states follows.

STATE	LUNG	BREAST	YEAR
Alaska	26	26	1981
California <sup>2</sup>	4100	4000	1983
Florida <sup>3</sup>	2130	1964	1982
Hawaii⁴	90	89	1982
Kentucky	558	548	1982
Louisiana	578	550	1982
Nevada <sup>5</sup>	96	72	1979
Oklahoma	451	448	1982
Oregon	405	386	1982
Texas	1797	1738	1982
Washing-			
ton6	631	583	1981
West			
Virginia	347	317	1982

- Lung cancer also surpassed breast cancer as leading cause of cancer deaths among women in Alaska in 1980—29 lung cancer vs 24 breast.
- California mortality figures predicted for 1983 by Donald Austin, chief of epidemiology for the California Department of Health Services, based on a reading of established trend: 1981—lung cancer 3507, breast cancer 3577; 1982—lung cancer 3851; breast cancer 3865.
- Lung cancer also surpassed breast cancer as leading cause of cancer deaths among women in Florida in 1980 and 1981. In 1980 there were 1812 lung cancer deaths and 1665 breast cancer deaths. In 1981 there were 1928 lung cancer deaths and 1874 breast cancer deaths.
- 4. Lung cancer first surpassed breast cancer as leading cause for cancer deaths among women in Hawaii in 1980—76 lung vs 68 breast. In 1981 there were more cases of cancer of the breast—84 vs 71 cancers of the lung.
- The Nevada State Health Department reports that it does not break down mortality statistics by site or sex. The 1979 figures are from National Center for Vital Statistics.
- 6. Lung cancer first surpassed breast cancer as leading cause of cancer deaths among women in Washington state in 1980, when there were 590 lung cancer deaths and 565 breast cancer deaths. This pattern continued in 1981, but in 1982 breast cancer deaths advanced to 643 while lung cancer deaths remained approximately level at 636.



## Snakeroot Extract

Number 2

July, 1984

## A NEWSLETTER OF INDIANA MEDICAL HISTORY

## **Society Receives Records of American Lung Association of Indiana**

The American Lung Association of Indiana (formerly the Indiana Tuberculosis Association) recently donated its large collection of records, photographs, books, and pamphlets to the Indiana Historical Society Library. The collection includes minutes from the Association's annual meetings, 1930-1971; minutes of the Association's Executive Committee meetings, 1938-1970; financial statements and budgets, 1939-1950; and records of sales of the Association's Christmas seals, 1936-1950. The donation also contains publicity scrapbooks, a variety of books and pamphlets, and over 150 photographs and negatives.

This collection represents the American Lung Association's second donation to the Indiana Historical Society Library. In 1982, the Indiana Historical Society received records, reports, and photographs from the state office from 1947-1960, a variety of records from the county tuberculosis associations, and a large collection of promotional material, pamphlets, artifacts, and posters.

The National Association for the Study and Prevention of Tuberculosis was founded in 1904 as part of a nationwide health movement to educate the public about tuberculosis and other communicable diseases. At that time, tuberculosis was still a leading cause of death. The organization's major goals were to study tuberculosis in all its forms; to disseminate knowledge about the causes, treatment, and prevention of the disease; and to encourage its prevention and scientific treatment. Along these same lines, the Indiana Tuberculosis Association was founded in 1907, with the enthusiastic support of legislators, physicians, and public health officials who had already been actively fighting the "white plague." In a whirlwind campaign, the Association worked with local organizations to build sanataria for tuberculosis patients.



The Indiana Tuberculosis Association sponsored a visiting nurses' program to educate the public about the causes, prevention, and treatment of tuberculosis. This photograph is part of the American Lung Association of Indiana's donation to the Indiana Historical Society.

(continued on Page 3)

## **Museum Corner**

The Indiana Medical History Museum recently received a set of mid-to-late nineteenth-century embryotomy instruments from Hugh N. Grimes, M.D. of Indianapolis. Included in the set were a crotchet, blunt hook, and perforator scissors.

Embryotomy instruments date to the 1600s. From the mid-1700s to the end of the nineteenth century, the style and shape of these instruments have undergone only slight alterations. Often in preternatural or difficult births, an immediate delivery was necessary to save the mother's life. In some cases, the child's position could not be altered. In many of these protracted cases of labor, the child had already died. Rather than perform a Caesarian section and endanger the mother's life, the physician would perform an embryotomy.

In an embryotomy (often referred to as a craniotomy), the physician destroyed the fetus within the uterus. Using both the perforator and the crotchet, the physician decapitated the fetus. The physician then used the blunt hook to grasp the fetus and extract it from the uterus. As can well be imagined, the embryotomy was a horrifying experience for women, but in some protracted births, the operation was an obstetrician's only hope of saving the mother.

With the introduction of the forceps in the mid-1700s, the number of embryotomies was drastically reduced. Although Peter Chamberlen the Elder (1560-1631) of London is credited with the invention of the short, straight forceps, the invention remained a family secret for many years. The Chamberlens were all midwives, and probably because of their secret invention, they claimed to be exceptional at their trade. A member of the succeeding generation of Chamberlens, Hugh Chamberlen, Junior (1664-1728), finally revealed the

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Snakeroot Extract is a joint publication of the Indiana Historical Society's Medical History Committee (315 West Ohio Street, Indianapolis, Indiana 46202) and the Indiana Medical History Museum (Old Pathology Building, 3000 West Washington Street, Indianapolis, Indiana 46222). The newsletter is mailed to members of both the committee and the museum.

Charles A. Bonsett, M.D., Editor

Ann G. Carmichael, MD., Ph.D., Asst. Editor Katherine Mandusic McDonell, Managing Editor

Submit all items for publication in the newsletter and inquiries about membership information to the Managing Editor, c/o Indiana Historical Society, 315 West Ohio Street, Indianapolis, Indiana 46202.

Snakeroot Extract derives its name from the white snakeroot plant, a plant that is significant in Indiana medical history. For years, a mysterious disease called milk sickness plagued early Hoosiers. There were many theories as to the disease's cause, but the actual cause remained unknown until the 1920s. At that time, the disease was traced to the white snakeroot plant or, rather, to the consumption of milk from cows that had eaten it. The plant contains the poison tremetol.



Photo by Seth Rossman

Embryotomy instruments (from left to right): blunt book, perforator scissors, and crotchet

instrument before his death.

During the 1700s and 1800s, physicians tried to improve upon the design of the cumbersome, straight forceps. Benjamin Pugh, a London male-midwife, introduced the pelvic curve to the forceps in 1740. William Smellie (1697-1793), also of London, tried to improve upon the design by replacing the wooden blades with steel ones, and covering the instrument with leather. Smellie's greater service to the obstetric art lay in his efforts to educate physicians on the use of the instrument in difficult deliveries, and he stressed that the forceps obviated the need for embryotomy. While the forceps did reduce the number of "craniotomies," the operation was still performed in cases of protracted labor throughout the nineteenth century.

## Museum Opens Medicinal Herb Garden

With the help of the Central Indiana District Garden Club, the Indiana Medical History Museum now has a medicinal herb garden. Helen Merrill and Jerri De La, both Garden Club members, were instrumental in the organization and planting of the garden. Included among the over twenty plants in the garden are digitalis, pennyroyal, tansy, horehound, mayapple, and butterfly weed. A program on the role of herbs in medicine is planned for September. The date of this program will be announced.

## **Society Receives Records**

(continued from Page 1)

The major source of financial support for the Association came from the sale of Christmas seals, originally sponsored by the Red Cross. The state association distributed posters on the disease, sponsored health parades, and mounted educational exhibits at schools and fairs. Moreover, the state organization founded "fresh air" schools for tuberculous children or children from tuberculous homes. The schools stressed the importance of fresh air in the cure of the disease.

By the 1940s, there was a drastic reduction in the number of deaths from the disease. By the 1950s, the battle against tuberculosis was almost won, and the national association expanded its scope to include other respiratory diseases such as asthma, chronic bronchitis, and emphysema. The Indiana Association followed the lead of the national organization and changed its name to the Indiana Tuberculosis and Respiratory Disease Association. In the 1970s, the name was changed again to the American Lung Association of Indiana. The records of this organization provide a rich source of material for those interested in the history of the American Lung Association of Indiana, as well as the entire public health movement in the state.

# TB RESPECTS NO AGE Be safe-Get a chest X-Ray

As part of its campaign against tuberculosis, the National Tuberculosis Association produced posters and distributed them to state associations. The above poster dates from 1957.



Children's Health Parade sponsored by the Indiana Tuberculosis Association in Fairmount, Indiana, ca. 1915. (Photograph in the collection of the Indiana Historical Society Library)



A scene from one of the Indiana Tuberculosis Association's "fresh air" schools, ca. 1915. (Photograph in the collection of the Indiana Historical Society Library)

## **Exhibit Extended**

The Indiana Historical Society's exhibit, "Medicine in Antebellum Indiana: Conflict, Conservatism, and Change," has been extended through August 31, 1984. Mounted in the exhibit gallery of the Indiana Historical Society, the exhibit depicts medicine and health in pre-Civil War Indiana and contains books, manuscripts, and artifacts from both the Indiana Historical Society and the Indiana Medical History Museum.

Copies of the accompanying catalog can be purchased from the Indiana Historical Society, 315 West Ohio Street, Indianapolis, Indiana 46202. The price of the catalog is \$2.40 (plus tax) for members of the Society and \$3.00 (plus tax) for nonmembers.

## Museum Presents Play as Fund-Raiser

On June 9, 1984, the Indiana Medical History Museum, in conjunction with the Mental Health Association in Marion County, sponsored an exclusive fund-raising event. The evening began with the presentation of the play, *Not Above a Whisper: A Portrayal of Dorothea Dix,* in the teaching amphitheater of the historic Old Pathology Building (which currently houses the Indiana Medical History Museum). Dorothea Lynde Dix (1802-1887) was a noted nineteenth century mental health reformer. The play had premiered at the National Portrait Gallery of the Smithsonian Institution. The play's performance at the museum represented its debut in Indianapolis. It was performed by Gayle Stahlmuth and Lee O'Connor, professional New York actors.

After the play, Dr. and Mrs. Glenn W. Irwin, Jr., program chairpersons for the event, hosted a champagne/dessert at their home for the invited guests. Program committee members included Mr. and Mrs. Thomas W. Binford, Dr. and Mrs. Otis R. Bowen, Mr. and Mrs. Joseph E. Crosby, Dr. and Mrs. Hugh C. Hendrie, Dr. and Mrs. Dennis S. Megenhardt, Mr. and Mrs. Kurt F. Pantzer, Jr., Mrs. Jeffery Pfaff, Dr. and Mrs. William M. Sholty, Mr. Herbert Simon and Diane Meyer Simon, Mr. and Mrs. Alfred J. Stokely, Mrs. Robert H. Staton, and Dr. E. L. Van Buskirk and Mrs. Joan Van Buskirk-Tanner.



Dorothea Lynde Dix (1802-1887)

Proceeds from the fund-raiser benefited both the Mental Health Association in Marion County and the Indiana Medical History Museum. The museum will use the money raised from this event to conduct a mechanical systems/architectural survey of the Old Pathology Building.

## T. S. DANIELSON, JR., M.D., M.P.H. Acting State Health Commissioner

## PUBLIC MEALTH MOTES

New information from Office of the Commissioner Indiana State Board of Health 1330 W. Michigan St. Indianapolis, Ind. 46206 317-633-8400

After more than two years' effort, we now have on the books the new rules governing the operation of Indiana's nursing homes and other similar health facilities. The passage of Senate Bill 60 in early 1982 was intended to have an effect on improving the quality of life for the residents of these homes, and the rules which are a result of SB 60 and now in effect achieve that lofty goal.

SB 60 (commonly known as the Nursing Home Reform Act and the Health Facilities Law) was the end result of a wave of nursing home reform efforts that included a General Assembly interim study committee on retirement and nursing homes—as well as the State Health Commissioner's Task Force on Care of the Aging and Aged—in 1981. These two groups reviewed the delivery of services in nursing homes, the standards of care, the enforcement of nursing home standards, and community alternatives to nursing home care such as home health care or adult day care.

Following the passage of SB 60 (which became PL 29), the Indiana Health Facilities Council appointed a rule-writing committee to develop and classify the rules required by the law. The committee was made up of a physician, a nurse, an administrator of a proprietary facility, a mental health professional, a representative of the Department of Public Welfare, and a representative of the State Commission on Aging.

The committee was asked to develop specific, enforceable rules which were resident-centered, could be easily understood by health care providers and consumers, and were compatible with current Medicare/Medicaid certification standards.

In their final form, the new rules are divided into six distinct parts. Rule 1 contains definitions of terms, Rule 2 discusses general requirements of health facilities, Rule 3 covers comprehensive care facilities, Rule 5 deals with residential care, Rule 6 talks about children in health facilities, and Rule 7 covers intermediate care facilities dealing with the mentally retarded. Rule 4 dealings with

intermediate care facilities was not approved.

Each rule is classified into one of four categories: an offense, a deficiency, a noncompliance, or a nonconformance. This classification was developed on the basis of the impact that the violation has on the health, safety, rights, security and welfare of the residents. Facilities found in violation can be requested by the State Health Commissioner to make immediate corrections; monetary penalties can also be assessed by the Commissioner against offending facilities.

Rule 3 (comprehensive care facilities) is of primary concern to physicians. For the first time, the state's rules for health care facilities mandate such facilities to retain the services of a medical director.

Specifically, Rule 3 says the medical director is to be responsible for "the standards, coordination, surveillance and planning for the development of medical care" in the facility. These responsibilities include:

- —overall coordination of medical services:
- —liaison between administrator and attending physicians in encouraging physicians to write orders promptly and to make resident visits in a timely manner;
- —review and evaluate resident care policies and procedures and guide the director of nursing services regarding resident care policies and services;
- —review accidents and incidents that occur on the premises to identify health and safety hazards;
- —review employee pre-employment physicals and health reports, and monitor employee health status; and
- —participate in facility committees regarding resident care policies, infection control, and pharmacy services.

Each resident of a health facility—or the resident's sponsor—shall select a physician, who must perform a physical examination on the day of admission or within the first 30 days of admission. The exam must include verification that the resident shows no evidence of communicable diseases, including tuber-

culosis in an infectious stage.

When residents are transferred from another home, a hospital or some other health institution, the report of a physical examination must be provided at the time of admission to the new facility or within 48 hours of admission.

The rules further specify that the physician must visit the patient at least every 35 days in the "distinct part of the facility which provides skilled care" and at least every 70 days in the "distinct part . . . which does not provide skilled care," with progress notes recorded in the resident's medical record. An alternate visitation schedule may be established in keeping with the facility's policy manual and with medical justification by the attending physician.

Other items in the new rules of particular interest to physicians include:

- —a resident's treating physician will be invited to attend a "relocation planning conference" for nonemergency involuntary interfacility relocations. This is a part of the new rule's added emphasis on increased respect for a resident's medical, pscyhological and social needs during a relocation to avoid "transfer trauma":
- —medication shall be administered only as prescribed by written order of the physician, and injectable medications shall be given *only* by licensed personnel;
- —any error in medication administration shall be noted in the resident's record. The physician shall be notified of any error, when there are any actual or potential detrimental effects to the resident;
- —a physician's order is necessary to continue restraint or seclusion of a resident beyond a 12-hour period;
- —new to the state's rules is the requirement that an infection control committee be established by each facility, and that it be composed of a physician, licensed nurse, pharmacist, and representatives of administration, dietetics, housekeeping, and maintenance departments;

CONTINUED ON PAGE 555

## Step ()ne

## One ... giving physicians and their detox patients a choice

A new option, called Step One, is now available in Central Indiana for the treatment of alcoholism.

For a moment, put yourself in the alcoholic's shoes. There've been real problems. You discover, however, that you want to overcome your dependence.

What are your options?

What do you, a physician, recommend?

You can try attending support groups and utilizing community service organizations, but they can't help with the chemical detoxification; and besides, are you strong enough to do it alone?

Another option is to spend three or four weeks in a detoxification center. You will be given individual attention and will have plenty of time to think about your plans for the future. But can you and your family afford a fourweek period of being away from work and home? Can your family easily explain your lengthy absence and institutionalization?

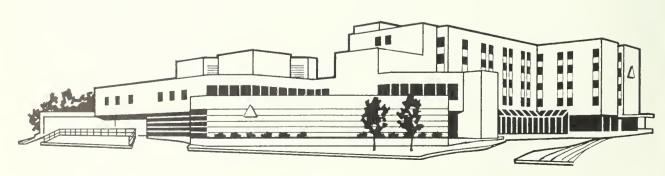
A third choice has been devised by Winona Memorial Hospital. A shortstay program, Step One gets the most out of a five or six-day stay.

Benefits to the patient include individual attention by the Alcohol Consultation Team comprised of nursing, social work, and chaplaincy personnel who support the physician; educational programs for both patient and family; treatment for withdrawal; group and individual counseling; low cost-per-day rates; and, upon dismissal, referral to appropriate community resources for further assistance and reinforcement. Furthermore, no social stigma is attached to admission to a full-service hospital—the reason for your stay, as well as your condition, will not be given out by any staff member.

As the physician of an alcoholic patient, you have your option as to the degree of involvement in his/her detoxification. You can admit your patients and maintain complete control of their care plan; you may prefer peer assistance in developing a treatment plan; or you may opt to turn treatment over to one of these alcohol-consultation physicians, with the understanding that following completion of the alcohol treatment, your patients will be referred back to you along with records of their progress. There is no medical director for the unit; rather, medical support is provided as requested.

Certified by the State Department of Mental Health, the program is committed to the goals of communication, education, and direction. It is truly the first step for the recovering alcoholic and is an attractive alternative in its treatment.

By contacting E. Randall Wright, Administration, at 927-2221, or Mary Ann Ohnen, Unit Patient Care Coordinator, at 927-2483, physicians can receive additional information or arrange a private unit tour.



INDIANA MEDICINE offers its readers a Continuing Medical Education series of articles prepared by the faculty of the Indiana University School of Medicine. The program is coordinated and supported by a grant from the school's Division of Continuing Medical Education.

As an organization accredited for continuing medical education, the Indiana University School of Medicine certifies that this CME activity meets the criteria for one credit hour in Category 1 for the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designated.

To obtain Category 1 credit for this month's article, complete the quiz on page 557.



## **Evaluation of Short Stature** in Children and Adolescents

JAMES C. WRIGHT, M.D. Indianapolis

HORT STATURE is the most common complaint of children and adolescents referred to pediatric endocrine clinics. There are many causes of short stature and this article will primarily focus on those that are most frequent.

The most widely accepted definition of short stature is "height that is three or more standard deviations below the mean for age and sex." A rate of growth consistently below that to be expected at a child's developmental age is indicative of the need for evaluation regardless of the height on a growth curve. Accurate serial measurements of height and weight and maintenance of a growth chart are essential aspects of health care of growing individuals.

## Standards of Growth

Growth charts, based on newer standards compiled by the National Center for Health Statistics of the United States Public Health Service, are widely available. Such charts demonstrate height

attainment by plotting height vs. age, and percentiles or standard deviations are used to show the wide range of measurements in a normal population. The 97th and third percentiles are approximately equal to two standard deviations above and below the mean. The height age of a child corresponds to the age at which the height equals the 50th percentile. A single plotted measurement on a growth curve may indicate short stature but multiple points are necessary to detect the presence or absence of ongoing growth failure. Evaluation of a growth chart provides the most valuable data in the investigation of a patient with short stature.

## History and Physical Examination

All prior measurements of the child with short stature should be obtained, if possible, beginning with birth weight and length. Adult heights and the growth and development patterns of relatives should be included in the family history. History of three generations is valuable

The author is director of the Pediatric Endocrine Service, Section of Endocrinology, Dept. of Pediatrics, Indiana University School of Medicine, Indianapolis.

Correspondence: James Whitcomb Riley Hospital for Children, 702 Barnhill Drive, Room A-586, Indianapolis, Ind. 46223.

## TABLE 1 Etiology of Short Stature

- Chronic disease (nonendocrine and nonskeletal) of the cardiovascular, pulmonary, gastrointestinal, urinary, central nervous, and hematological systems
- 2. Skeletal dysplasias
- 3. Undernutrition
- 4. Disorders of carbohydrate, lipid and protein metabolism
- 5. Chromosome abnormalities
- 6. Endocrine disorders
  - a. Hypothyroidism
  - b. Growth hormone deficiency
  - c. Glucocorticoid excess (endogenous or iatrogenic)
  - d. Premature closure of epiphyses in precocious sexual development or virilizing syndromes
  - e. Pseudohypoparathyroidism
- 7. Psychosocial short stature
- 8. Constitutional delayed growth and physical maturation
- 9. Intrauterine growth retardation (primordial short stature)
- 10. Genetic (familial) short stature

and usually available. Inquiry should specifically be made about any known cases of short stature. Psychological and developmental data are of particular importance.

Evidence of systemic disease, body proportions and level of sexual maturation are important aspects of the physical examination. The ratio of upper body segment to lower body segment (U/L ratio) and the relationship between arm span and height are the body proportions most widely used. The U/L ratio is increased in primary skeletal disorders and prolonged hypothyroidism due to relatively short extremities.

## Skeletal Maturation (Bone Age)

Most of the disorders that cause short stature in children and adolescents are associated with delayed skeletal maturation. The major value of determining bone age is prognosis for growth potential. Determination of bone age does not provide specific diagnostic information, but bone age tends to be within normal limits in genetic short stature, in most cases of primordial short stature, and in some patients with gonadal dysgenesis.

The Gruelich and Pyle Atlas of roentgenograms of the hand and wrist offers the best standardized method for

evaluating skeletal maturation or bone Roentgenograms hemiskeleton allow study of the total number of epiphysial centers as an alternative method in infants or when clinical impressions are at variance with bone age determined from only the hand and wrist. Before the onset of adolescent sexual development, determination of bone age is used as an index of physical maturation. The Bailey-Pinneau tables are published in the Gruelich and Pyle Atlas and offer the simplest method of height prediction. The patient's chronological age, bone age and current height are used in this prediction.

## General Laboratory Studies

When the cause of short stature is not clear, indicated laboratory studies include a complete blood count, urinalysis including urinary pH, blood pH or bicarbonate content, sodium, potassium, chloride, blood urea nitrogen or creatinine, serum cholesterol, calcium, inorganic phosphate, alkaline phosphatase and total protein. Determination of serum thyroxine by radioinimunoassay is useful. Level of skeletal maturation should be measured. If there is evidence for a central nervous system lesion or if hypopituitarism is strongly

suspected, x-rays of the skull should be obtained. Tests for determination of pituitary growth hormone levels are discussed below.

## Causes (Table 1) and Diagnosis of Short Stature

Children with chronic systemic disease rarely have short stature as their primary complaint, and their symptoms will usually make obvious the existence of an additional major problem. Children with congenital heart disease or chronic pulmonary disease may be shorter than their healthy peers. Malabsorption which leads to nutritional deficiencies is probably the leading cause of growth failure associated with gastrointestinal disease, although anorexia may be a contributing factor. Diminished growth rate may occur prior to specific gastrointestinal symptoms in patients with inflammatory bowel disease.

The cause of growth failure in children with chronic renal disease is not entirely clear, but chronic metabolic acidosis is recognized as a deterrent to normal growth. Severe mental retardation is frequently accompanied by short stature. Chronic anemias and acute leukemias have been associated with growth failure but other signs and symptoms are manifested before growth is influenced. The diagnosis of an osteochondrodystrophy is usually suggested by physical appearance, especially disproportion of body segments, and is confirmed by skeletal roentgenograms.

Growth failure resulting from undernutrition is preceded by failure of weight gain and weight usually falls to a greater degree than does height. Poorly controlled insulin dependent diabetes mellitus and untreated, or incompletely treated, inborn errors of metabolism can be associated with growth failure. With the exception of abnormalities of the X chromosome, children with chromosome abnormalities associated with short stature or growth failure present with other complaints or findings at the time of diagnosis.

If glucocorticoid excess is iatrogenic the cause of the associated growth failure

is obvious and if glucocorticoid excess is endogenous then growth failure is very rarely the chief or only complaint. Precocious sexual development and virilizing disorders are associated with increased height in childhood and shortening of adult stature due to premature closure of epiphyses. Early cessation of growth might occasionally be the cause of the complaint of short stature in an adolescent who has exhibited precocious sexual development. Although short stature is a frequent accompaniment of pseudohypoparathyroidism, patients with this entity usually present in mid-childhood with symptoms associated with hypocalcemia.

The diagnoses discussed below represent those that generally form the differential diagnosis of the child or adolescent who presents with short stature and/or growth failure as the chief, or only, complaint.

A diagnosis of gonadal dysgenesis or Turner's syndrome should be considered in all phenotypic females with short stature. Frequently associated somatic abnormalities are noted in Table 2 and should be looked for. Moderate pubic hair development at the usual age of adolescence is common; however, breast development is absent except in XO/XX mosaics in whom there may be slight development. Sterility is the rule. Height is below that expected by school age in almost all patients. Growth rate continues to be subnormal and there is no adolescent "growth spurt." Decreased stature is always found but the degree is variable and there is a genetic component involved in ultimate height.

If there is no other obvious cause of short stature, girls should have chromosome analysis of peripheral lymphocytes. A missing sex chromosome with an XO complement is the most common abnormality in karyotyping. Mosaic forms such as XO/XX and XO/XY are also associated with Turner's syndrome, as are structural abnormalities of an X chromosome. The staining of a buccal smear to determine the presence or absence of Barr bodies is of limited usefulness and rarely done

TABLE 2
Abnormal Findings in Patients with Turner's Syndrome

	Abnormality	Approximate Incidence (Percent)
1.	Growth failure	100
2.	Short stature	95-100
3.	Infertility	99.9
4.	Gonadal failure	95-100
5.	Shield chest	75-90
6.	Micrognathia	60-90
7.	Short neck	40-90
8.	Narrow high arched palate	36-90
9.	Cubitus valgus	47-80
10.	Low posterior hair line	42-80
11.	Multiple pigmented nevi	26-70
12.	Webbed neck	25-60
13.	Pectus excavatum	40-50
14.	Edema of hands/feet or puffiness of toes	22-50
15.	Short 4th metacarpals	20-58

at this time. If done, buccal smear staining and interpretation should only be performed in laboratories with a high volume of such tests and with expert and experienced technical personnel. Demonstration of elevated follicle stimulating hormone (FSH) and luteinizing hormone (LH) confirms the presence of primary gonadal failure.

When acquired (or juvenile) hypothyroidism occurs after the age of two years, growth failure may be the principal or in some cases the only complaint. Associated symptoms may be elicited through a careful and detailed history. These symptoms include decreased activity, cold intolerance, increased hours of sleep, constipation and tendency to gain weight. Physical signs may include cool and dry skin with sallow complexion, puffiness of the face (especially around the eyes), and coarse, brittle hair. The most characteristic growth pattern in acquired hypothyroidism is an almost complete cessation of longitudinal linear growth.

T<sub>4</sub> by radioimmunoassay is the only chemical determination which must be done initially for the indication of thyroid function. Should the T<sub>4</sub> be low, determination of TSH (thyroid stimula-

tion hormone) should be carried out to determine whether the hypothyroidism is primary or secondary to hypothalamicpituitary dysfunction. Most cases are primary.

Hypopituitary dwarfism may be organic or idiopathic, sporadic or familial. Although suprasellar tumors are principal cause. hypopituitarism may be seen in destructive or invasive lesions of the brain, e.g., histiocytosis or Hand-Schuller-Christian disease, which affect releasing hormones from the hypothalamus. Patients with organic hypopituitarism usually present for medical attention because of neurologic or visual abnormalities, whereas patients with idiopathic hypopituitarism usually present with growth failure or spontaneous symptomatic hypoglycemia. Idiopathic hypopituitarism may be most frequently a result of hypothalamic dysfunction rather than a primary defect of pituitary function. History of perinatal insult to the central nervous system is increasingly recognized as an etiological factor in the development of idiopathic hypopituitarism.

To establish a definitive diagnosis of growth hormone deficiency, it is

nccessary to demonstrate failure of response to at least two of the standardized provocative tests for growth hormone release. These provocative tests include insulin-induced hypoglycemia, intravenous infusion of L-arginine, oral administration of L-dopa and intramuscular injection of glucagon. Administration of oral estrogen for three days before and/or oral propranolol two hours before are frequently used as primers for the testing.

Pituitary growth hormone does not directly stimulate skeletal growth, but rather stimulates the production of somatomedins which, in turn, stimulate longitudinal linear growth. somatomedin is a growth promoting, circulating polypeptide dependent upon growth hormone for stimulation of pro-Radioimmunoassay duction. somatomedin C has proven to be a useful screening test for growth hormone deficiency. Evaluation of thyroid and adrenal function is indicated in a child with deficiency of pituitary growth hormone. Tests for gonadal function are indicated in the teen-age patient.

Psychosocial dwarfism (deprivation dwarfism) is the term currently used for the short stature observed in children from an emotionally deprived environment. Associated behavioral aberrations may include polyphagia associated with eating garbage and frequent vomiting; polydypsia to the extent of drinking from unusual sources such as toilet bowls; and disoriented sleep patterns associated with night wandering with foraging for food. Frequently there are other behavioral manifestations such as "flat" personality, and nondiscriminating attachment to parents or strangers. There is an associated retarded bone age and, in adolescents, delayed sexual maturation. Growth rate usually shows a marked increase upon removal of the child from the environment in which the child is living to a more health-promoting setting.

During periods of diminished growth rate there is frequently evidence of growth hormone deficiency. Adrenocorticotropin (ACTH) deficiency has been found in many patients. Thyroid function is unaffected. During periods of normal or accelerated growth, pituitary function studies are found to be normal. Impaired neurotransmitter function, sleep disturbance and malnutrition have all been suggested as causes of the growth failure in psychosocial dwarfism.

Constitutional delayed growth and physical maturation is the most common diagnosis made in children and adolescents with short stature, and is observed more commonly in males than in females. However, parental concern for height in males is more evident and contributes to the marked predominance of males reported from most clinics. There is a family history of delayed growth and development patterns in approximately 40% of children with this diagnosis seen in the author's clinic. These patients do not have any known endocrine dysfunction, and the cause of the condition which is associated with slow attainment of adult height is unknown. Typically, these children are normal in size at birth and throughout infancy. They fall away from the normal growth curve during the preschool years and then demonstrate a normal growth rate without any "catch-up." During childhood the height of affected children tends to be equivalent to about the 50th percentile for the children of the same sex who are two to four years vounger. Bone age is characteristically comparably delayed, i.e., by two to four years. Endocrine function studies are normal. A child who has retarded height age, comparably retarded bone age, a history of normal size at birth, and no abnormal endocrine function studies usually has constitutional delayed growth and physical maturation. Because of delay in physical maturation, they usually catch up through a prolonged period of growth prior to closure of the epiphyses. Many patients with moderate to severe constitutional delayed growth and physical maturation are diagnosed only after the determination that endocrine function is normal.

Primordial dwarfism, a term traditionally used to designate a child with short stature who does not have a delay in physical maturation, is a diagnosis that should be limited to those children who have *intrauterine growth retardation* (*IUGR*) with persistent small size. Characteristically, growth is slow from earliest infancy although epiphyseal maturation and sexual development usually occur at the usual time or at only a slightly delayed rate. There is an increased incidence of mental retardation and other developmental somatic abnormalities.

The length of gestation and the measurement of weight and length at birth provide the history necessary to make the diagnosis of IUGR. Endocrine function studies are normal. Bone age is usually within two standard deviations of mean and adolescent sexual maturation occurs also within two standard deviations of the mean age.

A diagnosis of genetic (familial) short stature is made from the family history and is the second most common cause of short stature evaluated in growth clinics. The diagnosis may be difficult in an adopted child. The term genetic short stature most frequently refers to genetic short normal stature. Many such children are brought to clinics for evaluation of short stature because of parental concern and the desire to correct final adult stature if possible. Skeletal maturation is within normal limits for patients with genetic short stature.

## Treatment of Short Stature

There is no effective treatment for IUGR or genetic short stature. Anabolic steroid therapy may be of use in children with IUGR who have delayed bone age. Skeletal maturation and liver function should be monitored while on anabolic steroids. Dosage of anabolic steroid for treatment of IUGR is the same as that noted below for the treatment of the short stature of Turner's Syndrome.

Treatment of both primary and secondary hypothyroidism is replacement with either desiccated thyroid, synthetic thyroid T<sub>4</sub>, or synthetic preparations which are mixtures of T<sub>4</sub> and T<sub>3</sub>. Replacement dosage of sodium L-thyroxine is 4-6 micrograms/kg/day

from age one to age five years, and 3-5 micrograms/kg/day after age five years. A dose higher than 150 micrograms/day is rarely required in children or adolescents. Growth response to treatment usually consists of "catch-up" growth rate followed by appropriate growth rate for the level of physical development with continued treatment.

Treatment of hypopituitarism involves replacement with the missing hormones from the target glands, i.e., thyroid hormone if thyroid function is deficient, glucocorticoid if adrenocortical function is deficient, sexual steroidal hormones if gonadal function is deficient, and growth hormone. Supplies of human growth hormone are still not adequate to treat all patients with hypopituitarism beginning at the time of diagnosis. The availability of recombinant growth hormone is anticipated within the next year. The dosage of thyroid replacement is identical to that used in primary hypothyroidism. The amount of glucocorticoid replacement is based on 15 mg of hydrocortisone per meter square body surface per day. Dosage of sexual steroidal replacement is variable. The amount of human growth hormone used is about 0.1 unit per kilogram body weight three times weekly.

Treatment for psychosocial dwarfism obviously involves alteration of the environment in which the child is functioning, either by transfer to a better one, or major intervention to improve the home in which the child lives.

No treatment is necessary to attain appropriate sexual maturation and genetically determined adult height in constitutional delayed growth and adolescence. After the age of 15, when continued short stature and sexual infantilism are associated with significant psychological problems, a short course of testosterone may be considered for these patients. A long-acting (depot) form of testosterone, 100 mg given intramuscularly every four weeks, may be used for four months. Such treatment should be undertaken with the goals of producing a fairly prompt, noticeable increase in growth rate as well as secondary sexual development, and of attaining a level of maturation of the hypothalmic-pituitary-gonadal axis, which will allow the patient to continue normal sexual development when treatment is discontinued. Treatment should also be undertaken only after assuring the patient that he is not abnormal, that sexual maturation and growth spurt will eventually occur without treatment, that treatment merely brings about these changes sooner, and that final adult height will not be increased by treatment.

Usual management of the short stature of Turner's syndrome involves the use of anabolic steroids for approximately two to three years prior to the initiation of estrogen replacement therapy at about age 14 years. Liver function should be monitored in patients on treatment with anabolic steroids. Oxandrolone, in a dosage of 0.1 to 0.25 mg/kg body weight per day in one or two doses, is used in the author's clinic. The anabolic steroid is then continued together with the estrogen replacement for approximately another year or until there is fusion of epiphyseal centers evident on x-ray. Treatment with estrogen therapy is then continued. Long-term use of estrogen should always be used in conjunction with progesterone.

Initial treatment with estrogen utilizes ethinyl estradiol 5 to 10 micrograms or conjugated estrogens (Premarin) 0.3 mg daily on the first 21 days of each calendar month. After six months, the dosage of estrogen is increased to 10 to 20 micrograms of ethinyl estradiol or 0.625 mg of conjugated estrogen. When the dosage of estrogen is increased, after six months, medroxyprogesterone acetate (Provera) 10 mg per day is added on the 17th through the 21st day of each calendar month.

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### Growth Hormone Deficiency

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## Prognostic Indicators in Critical Care

DAVID J. POWNER, M.D. Indianapolis

PREDICTION OF OUTCOME is an inherent and often unconscious part of each physician's daily practice. The formulation of diagnostic or therapeutic care plans, completion of medical records, and conversations with patients or family members are but a few examples of activities dependent upon anticipated prognosis.

Traditionally, prognostic expectations are based upon knowledge of the disease state in question, information from published medical trials, and experiences from patients with similar conditions. Each of these resources may be considered to a greater or lesser degree (weighed) and further modified by factors or indicators unique to the individual patient's presentation, diagnostic data, therapeutic responses, evolution of the disease itself, and other concomitant conditions or injuries. This rather subjective weighing process is finally concluded in the prognostic statement utilized for decision-making and discussion.

Clearly, therefore, as a patient's condition becomes more complex, thus encompassing more indicators, this prediction process may become similarly complex. Yet in such patients, the question of prognosis becomes more focused as costly tests or services become needed, more nursing or paramedical care is required, or the family's concerns escalate.

Several statistical rating methods based

The author is Medical Director, Adult Critical Care Units, Methodist Hospital of Indiana, 1604 N. Capitol Ave., Indianapolis, Ind. 46206.



Several
Statistical
Rating Methods
Have Been
Devised to
Evaluate
Patients
Requiring
Critical Care

upon objective measurable data have not only been proposed but also retrospectively and prospectively evaluated for some patient groups requiring critical care. This article will review some of those systems, their application, and reliability. Other systems describing noncritical illness,1 trauma,2 and sepsis,3 and intensive care4-7 are also available for the reader's examination. Each of these systems at present is advocated only for the analysis of populations of patients or for comparison of treatment regimens or hospital programs and any extrapolation to individual patient prognosis is intended to be only inferential. Nevertheless, the extension to individuals of statistical data from larger patient populations as this influences prognosis is already a part of current practice. Therefore, information from such predictive models may become more important in determining for individual patients when costly resources should be extended within a particular care plan.

### TISS

The Therapeutic Intervention Scoring System (TISS) developed by Cullen and Associates<sup>8</sup> at Massachusetts General Hospital is a weighed system of 57 treatments, clinical events, or monitoring techniques, each of which is assigned a point value (1 to 4 points) based upon the perceived severity of illness requiring that intervention. For example, the most critically ill surgical patients in his series averaged 43 points, indicating a large number of complex interventions.

The system assumes that the more ill a patient the more interventions will occur and that a fairly standard response will occur to a given illness in terms of what interventions (hemodialysis, IV medications, etc.) are utilized and when they will be instituted by user physicians. Likewise, the system is based upon the premise that regardless of the underly-

ing disease, organ dysfunction occurs in a manner which requires a fairly standard interventional response. By tabulating a TISS score daily, an inverse correlation was found between the TISS points, duration of ICU admission, and primary disease process versus patient survival while the absolute TISS score itself was less predictive.

From a statistical discriminate analysis, age, sex, American Society of Anesthesiologists' risk category, disease group, admission platelet count, admission creatinine, worst creatinine, and use of dialysis were the prognostic indicators having highest validity in predicting death. The TISS criteria are easily measurable and provide a useful tool for the evaluation of a specific hospital's intervention acuity patient mix as that compares to other centers or as that changes over time.

## **Predictive Index**

Shoemaker and co-workers° have provided retrospective and prospective evaluation of a system which has a 94% accuracy in predicting survival or death in a population of critically ill postoperative patients usually in shock. Based on a multivariate analysis of 32 directly measured or calculated physiologic variables, the system is limited primarily to patients with circulatory instability and does not include evaluation of some organ systems (e.g., renal).

It was found that some indicators were more predictive in various stages of cardiopulmonary collapse or recovery than in others but the combination of each variable with an independent predictive index over the therapy course produced a high degree of prediction accuracy which appeared relatively early in the unstable patient's post-operative course and remained reliable.

## **APACHE**

The Acute Physiology and Chronic Health Evaluation (APACHE) classification <sup>10</sup> scheme combines four letter designations (A through D) describing the degree of chronic health restriction with a numeric point value based on how

much the patient's current (acute) status deviates above or below the normal value for 34 indicators. A score of 36D, therefore, would represent a patient with a severe acute physiologic derangement superimposed upon chronically poor health.

Validation studies of the system indicate that the overall correlation of total points to hospital mortality was represented by an r value of .51, but that with greater than 31 points the probability of dying in the hospital was 70%. Similarly, the chronic health status rating was independently correlated with mortality. Of 519 patients who were predicted to survive, using a combined acute and chronic evaluation 467 (90%) did survive while of 63 patients in whom death was predicted 50 (79%) did die. This produced an overall misclassification rate of 11% with a false-positive incidence of 10% and a false-negative rate of 21%.

A multicenter international prospective evaluation of APACHE is in progress and a preliminary report appears to support the system's predictive ability in a variety of critical care units.<sup>11,12</sup>

### Discussion

The ability of a hospital to objectively define the patient mix it serves is clearly one application of the acuity rating systems discussed above. Such analysis will be a necessary response to hospital reimbursement policies based upon either diagnostic categories or which contain modifiers for severity of illness. The physician, too, may benefit from an analysis of his/her patient mix relative to time allocations, consultative practices, directions for future practice goals, and utilization of special techniques or services. These systems, therefore, provide direct objective data for such population analysis.

The utilization of prognostic indicators by either large health care systems, individual hospitals, or private physicians, to examine or influence resource allocation is one logical extension of their development. The application of such a tool to population groups as shown above appears to be reliable with a degree of error of about 10%. That

magnitude of error may still be unacceptably high when applied to individual patients but the concept implied by this type of analysis system must soon be addressed by those responsible for patient care and the consumption of finite resources.

Specifically, the question which must be addressed soon is whether a system such as discussed above should be used to assist or influence the physician's decision-making process in determining prognosis so that the utilization of costly diagnostic studies or therapies may be directed toward the care of individual patients who have a more favorable predicted outcome.

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## Riley Children's Hospital Ureteroceles: A 12-Year Experience

BRENT W. SNOW, M.D. MICHAEL E. MITCHELL, M.D. ROBERT A. GARRETT, M.D. Indianapolis

### Abstract

A 12-year experience with ureteroceles in 31 patients treated at the Riley Children's Hospital is reviewed. Important aspects of diagnosis and management are emphasized.

URETEROCELE is a cystic dilatation of the intramural and intraveslical ureter and represents a cause of ureteral and bladder obstruction in children. It can be associated with a single ureter (adult type) or more commonly with a duplex renal system. When a ureterocele is found in such a double system, it is associated with the upper pole ureter which may terminate in an abnormal location. When a ureterocele is contained entirely within the bladder, it is termed intravesical. Some ureteroceles, however, extend into the bladder neck or beyond and are termed extravesical or ectopic. The ureterocele is an uncommon malformation occurring in about 1/20,000 live births and can result in a broad spectrum of clinical and pathologic findings. The most common presenting symptom is urinary infection.

### Material and Methods

Thirty-one patients in whom ureteroceles were found at James Whitcomb Riley Hospital for Children from 1970 to June 1982 were retrospectively studied by chart review.

From the Dept. of Pediatric Urology, James Whitcomb Riley Hospital for Children 248, 702 Barnhill Drive, Indiana University Medical Center, Indianapolis, Ind. 46223.

## Results

There were 25 females and six males, a 4.2:1 female-to-male ratio. Ages ranged from the newborn period to 13 years of age. Nineteen patients (61%) presented in the first year of life as can be seen in *Table 1*. As noted in *Table 2*, infection was the most common presenting symptom.

Twenty-five patients had unilateral ureteroceles, 16 on the right and nine on the left. Six patients (19%) had bilateral ureteroceles. Twenty-one of the 37 ureteroceles (57%) extended beyond the bladder neck and were, therefore, classified as ectopic.

Hydronephrosis was seen in the opposite kidney (without associated ureterocele) in three patients. This was felt to be related to reflux and/or bladder outflow obstruction. Decreased function was present in 13 ipsilateral upper pole segments, five ipsilateral lower pole segments, and in one kidney with a solitary ureter. In all cases function in the non-involved kidney was normal.

Voiding cystourethrograms were obtained on 28 of the 31 patients prior to any surgical procedures. Reflux was found in 12 patients (42%) and bladder diverticula in three.

Laboratory determinations showed only two patients with blood urea nitrogen elevations (greater than 20 mg/dl) and there were three patients with acidosis reflected by CO<sub>2</sub> levels below 17 mg/dl.

A total of 59 procedures were performed on 31 patients. Initial cystoscopy was commonly performed and the ureterocele orifice was identified in only 11 patients (40%).

Twelve patients had only one procedure while the remaining 19 patients had two or more procedures (*Table 3*).

Ureteroceles will often involve the trigone sometimes extending across the midline and even through the bladder neck. The presence of vesicoureteral reflux due to poor ureteral tunnel development may be anticipated. Reflux in this series was noted in 12 patients.

## TABLE 1

## Age of Presentation

Less than 1 month	9
1-3 months	5
3 months-1 year	5
1-5 years	6
5-13 years	6
	31 patients

Age of initial treatment for 31 patients with the diagnosis of ureterocele treated at James Whitcomb Riley Hospital for Children.

## TABLE 2

## Findings at Presentation 31 Patients

i mongs at 1 resemble on e i	
Infection	27
Obstruction	12
Infection/Obstruction	8
Ureterocele Prolapse	3
Urinary Retention	2

Presenting symptoms of 31 patients treated at James Whitcomb Riley Hospital for Children.

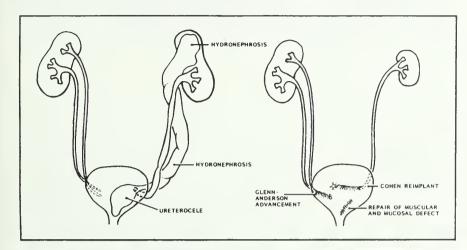
## TABLE 3

## Procedures

- 11 patients had 1 procedure
- 14 patients had 2 procedures
- 3 patients had 3 procedures
- 1 patient had 4 procedures
- 1 patient had 6 procedures

Totals: 30 patients\* 58 procedures

\*1 patient had cystoscopy only.



THIS IS A CASE of a young girl with a urinary tract infection who was found to have a ureterocele associated with a duplex kidney on the left.

FIGURE 1A: This represents the anatomy before and after reconstruction surgery. The large ureterocele extended through the bladder neck into the urethra. Vesicoureteral reflux was observed bilaterally. The nonfunctioning dysplastic upper pole system with the ureterocele was removed and the large muscular defect in the posterior bladder wall was repaired; all ureters were reimplanted.



FIGURE 1B: Intravenous pyelogram prior to surgery shows the "wilting flower" appearance on the left and the ureterocele (filling defect) in the bladder.



FIGURE 1C: Intravenous pyelogram after surgery is essentially normal.

Furthermore, because of the major degree of anatomic deformity, spontaneous resolution of lower pole reflux with ureterocele decompression by upper pole heminephrectomy may not be anticipated. Likewise, ureteroneocystostomy in such patients is difficult and may be unsuccessful. For example, after one operation eight patients in the entire group had vesicoureteral reflux. The sim-

ple incision or "unroofing" of a pediatric ureterocele will invariably lead to reflux and such a procedure is reserved only as temporary drainage in a sick infant.

### Discussion

It has been suggested that ureteroceles are due to persistence of Chwalla's membrane. This delays incorporation of the caudal end of the ureteral buds into the urogenital sinus and allows for cystic dilatation of the distal ureter. This explanation, however, does not account for the broad spectrum of ureteroceles. Stephens¹ suggests that ureteroceles form as a defect in the embryogenesis of the ureter and its associated renal segment and not secondary to obstruction.

Ureteroceles, despite their infrequent occurrence, are the most common cause of lower urinary tract obstruction in girls. They are also one of the three most common causes of hydronephrosis in infancy.<sup>2</sup> Their diagnosis depends on a high index of suspicion in the child with urinary tract infection, particularly with lower urinary tract obstruction and/or hydronephrosis. Careful diagnostic evaluation with excretory urography, voiding cystourethrography, ultrasound and renal scan should be performed in all such patients.

Management of ureteroceles has been widely discussed in the literature with some authors preferring a complete single-stage approach<sup>3</sup> and others preferring either a modified one-stage procedure<sup>4</sup> or staged procedures.<sup>2,5,6</sup>

A simple ureterocele associated with

a single ureter can easily be excised and the ureter reimplanted. The management of a ureterocele associated with the upper segment of a duplex system depends greatly on the individual patient. Endoscopic unroofing of the ureterocele results in vesicoureteral reflux and is now used only to achieve drainage in the acutely ill patient.

In our experience we have used both staged approaches and single-stage total reconstructions. In seven patients who had only upper urinary tract procedures, four required no further surgery. In six patients, a combined upper and lower urinary tract repair was undertaken as described by Hendren and Mitchell.<sup>3</sup> Two of these patients developed bladder diverticula which are physiologically insignificant at this time.

The problem of vesicoureteral reflux both before and after repair indicates only the difficult nature of the ureterocele problem. If the ureterocele is large, particularly if it extends into the proximal urethra, there results a major muscular defect in the posterior bladder wall and bladder neck. Even with careful reconstruction of the posterior bladder wall and with ureteral reimplanation, the risk of persistent reflux is significant because of the poor support of the ureteral tunnel. As well, females with a large ureterocele that extends through the

bladder neck into the urethra may have a problem with urinary incontinence. Such patients require reconstruction of the bladder neck.

The ability to diagnose a ureterocele is dependent upon a high index of suspicion and careful diagnostic evaluation of all children with infections, bladder outlet obstruction and/or hydronephrosis. Because of the spectrum of the disease, treatment must be individualized to suit the particular clinical situation. A complex ureterocele case can be among the most difficult challenges to confront the pediatric urologist. The ureterocele problem is very much like the iceberg—much more to it than one sees on the surface.

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injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section). **Warnings:** *Brug Dependence*. Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head wayry and Increased Intracramal Pressure*. As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CD<sub>2</sub> retention, these effects may be a pasted the superconduction of the processing of the processors of the pressure due to CD<sub>2</sub> retention, these effects may be a pasted to the processors of the pressure due to the processors of the pressure of the pressur cerebrospinal fluid pressure due to CD<sub>2</sub> retention, these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries, in such patients, use with extreme caution and only if deemed insential *Usage with Alcohol*. Due to potential for increased CNS depressant effects, alcohol should be used with caution *Patients Receiving Nacotics*. Pentazocine is a mild narcotic antagonist Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions*. Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve severe bronchial.

any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis Precautions: CNS Effect Use cautiously in patients prone to serzures, serzures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare asthma and other obstructive respiratory conditions, or cyanosis Precautions: CNS Effect. Use cautiously in patients prone to seizures, serzures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations, fusually visuall, disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be every closely observed and vital signs necked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may refur Impaired Renal or Hepatic Function. Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairment in long-term use, precautions should be taken to avoid increases in dose by the patient. Bilinary Surgery. Some evidence suggests that unlike other nacrotics pentazorine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known. Intormation for Patients. Since sedation, dizzness, and occasional euphonia have been noted, ambulatory patients should be warned not to operate machinery drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alohe and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. Myocardial Infarction. Use with caution in patients with myocardial infarction who have nauses or vomiting. Drug Interactions used in animals to test for carcinogenesis have been performed Pregnancy Calegory C'Should be given to pregnant women only it clearly needed. Labor and Delivery Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. Nursing Mothers Caution should be

misuse and abuse by the oral route. Severe, even lethal, consequences may result from misuse of tablets by rige from either alone or in combination with other substances, such as pulmonary embolic vascular occlusion ulceration and abscesses and withdrawal symptoms in narcotic dependent individuals. Dverdosage: Treatment: Dxygen, intravenous fluids, vasopressibility, and other supportive infeasures should be employed as individual Assisted or controlled ventilation should also be considered for respiratory depression, parenteral nalixone (Narcan, available through Endo Laboratories) is a specific and effective antagonist.



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### BRIFF SUMMARY

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PROCARDIA in ted poir CAPSULES —— For Grall INNOCATIONS AND USAGE. Il Vasospastic Angina PRO . Ri I A intedipor in indicated for the trial ignored by any indicated to the six ignored by a right at the fact comparised by a frequent tervator. 2 and sacon on mary artery, pain in proceedings a six of the fact and any organization as y demonstrated unionary artery, pain in this replacement is wind and organization presented of ignored and the above order a are sait, the displacement with the diagnosis of vasospastic and sa provided that the above order a are sait, the displacement but where valospasm hair of been confirmed leight where valospasm hair of the electrocard organization displacement but where valospasm hair of the electrocard organization displacement but where valospasm hair or when anomal increased. Effect Accomplished Accomplished with order that valority and a control of the provided provided and a control of the provided Accomplished Accomplished

numerable angina where electron and ographic findings are compatible with intermittent vaso past for when angina in retractory to nutrate and or adequate dose of beta blookers. If Chronic Stable Angina (Classical Effort Associated Angina) PROCARLINA is indicated for their anagement of unrolling table angina retfort associated angina, without evidence of validspan apatient who remain symptomatic despite adequate dose of beta blookers and or organic in trates is who cannot to relate those agent. In chronic stable angina reform a tendangina (PROCARDIA has been effective in controlled that's of up to eight weeks duration in reducing angina frequency and increasing exercise objectance but confirmation of sustained effectivenes, and evaluation of ong term safety in those patients are incomplete.

nrompiete Controlled studies in small numbers of patient, suggest concomitant use of PROCARDIA and beta blues inglagents may be beneficial in patients with chronic stable angina, but available information, sind sufficient to predict with confidence the effects of concurrent freatment especially in patients with compromised left ventricial it function or cardiac conductors abnormalities. When in troducing such concomitant therapy, care must be taken to monitor blood pressure closely. Since evere hypotension can occur from the combined effects of the drugs. (See Warnings) in CONTRAINOICATIONS. Amony hyperensist vely reaction to PROCARDIA.

WARNINGS Excessive Hypotension. Although in most patients, the hypotensive effect of PROCARDIA's modest and well toierated, occasional patients have had excessive and poorly to erated hypotension. These responses have usually occurred during initial thration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

subsequent upward dosage adjustment, and may be morelisely in patients on concomitant beta blockers. Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery us in high dose tentanyi anesthesia. The interaction with high dose tentanyi anestras to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone with low doses of tentany in other surgical procedures or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentany anesthesia is contempated, the physician should be aware of these obtential problems and the patient's condition perm is sufficient from lat least 36 hours; Ishould be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina. Dicasional patients have developed well documented increased frequency, duration in severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a with drawal syndrome with increased angina, probably related to increased and might be expected to exacerbate if by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA tration. It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for

resistance careful monitoring of blood pressure during the initial administration and fitration in PRDCARDIA such an event.

PRECAUTIONS General Hypotension Because PROCARDIA decreases peripheral vascular resistance careful monitoring of blood pressure during the initial administration and fitration in PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema. Mid to moderate peripheral edema typically associated with arterial vasoulation and not due to left ventricular dystunction, occurs in about one in ten patients. Treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic herapy. With patients whose angina is complicated by congestive heart failure care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction. Drug inferactions Beta-adherengic blocking agents is suicilly well folerated but there have been occasional interature reports suggesting that the combination may increase the likelihood of congestive heart failure. Severe hypotension or exacerbation of angina. Long acting intrates. PROCARDIA may be safely co administered with intrates but there have been no controlled studies to evaluate the antianginal effectiveness of this combination. Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve mormal volunteers. The average increase was 45°. Another investigator found no increase in digoxin levels in thirteen patients with coronary aftery disease. In an uncontrolled study of over two mundred patients with coronary aftery disease. In an uncontrolled study of over two mundred patients with coronary aftery disease. In an uncontrolled study of over low of under displants toxicity was not observed. Since there have been isolated reports of patients with coronary aftery disease. In an uncontrolled study of over low of under displants toxic

dipine caused reduced tertulity at a dose approximately 30 times the maximum recommended human dose. Pregnancy Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys. ADVERSE REACTIONS. The most common adverse events included dizziness or light-headedness peripheral edema nauseal weakness, headache and flushing each occurring in about 10% of patients. Transient hypotension in about 5% palpitation in about 2% and syncope in about 05%. Syncopal episodes did not recur with reductor in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported muscle cramps, nervousness dyspined in abasiliant of these congestion diarrhea constipation inflammation joint stiffness. Shakness sleep disturbances. Burred vision difficulties in balance, dermatitis, pruntus, urticaria, lever sweating chilis, and sexual difficulties. Very rarely introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension. In addition more serious adverse events were observed in interactly distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were observed in terracity distinguishable from the natural history of galitic and constitutions of the proposition of the disease in these patients. It remains possible, however, that some or many of these events were observed in fewer than 0.5% of patients.

Laboratory Tests Rare midd to moderate transient elevations of enzymes such as alkaline phosphatase was seen in a patient with a history of galit bladder disease after about eleven months of intediprine therapy. The relationship to PROCARDIA therapy is uncertain. These, aboratory abnormalities have rarely been associated with clinical symptoms, holestase, possibly due to PROCARDIA therapy, has been reported twice in the extensive world terature.

Iterature

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2) Angina where the clinical presentation suggests a possible

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J-4044 January 1984

### **Experimental Medical Devices, Drugs and Techniques**

Their Future Social, Medical and Political Implications (Part 2)

OTIS R. BOWEN, M.D.\*
Indianapolis

R. GARY KOPF, chief of pediatric-cardiac surgery at Yale-New Haven Hospital and a member of the Human Investigation Committee at Yale, said: "Whenever a new device is tried on a human, it is experimentation and the issue is that it be tried on patients for whom there is no alternative therapy. If that is the case and life is prolonged, the procedure is justified. I think it is the right way to go."

The November 1981 issue of the American Lung Association Bulletin reported on two heart-lung transplants at Stanford University. One occurred in April 1981 and the other in May 1981. These two operations opened the doors wider in transplant surgery and will help to a better understanding of the human body. Understandably, these operations made news around the world. A diseased heart may cause lung damage and vice

versa, which is the reason the researchers transplanted both organs into two desperately ill volunteers.

The bulletin does not imply that these exciting, challenging, innovative, instructive, extraordinary and hugely expensive

In Experimental
Medicine, Criticism
Will Become More
Plentiful . . .
In the Development
of New Devices,
Competition Will
Increase . . .
The Ethics of Our
Society Shall Prevail
and Cost Will Be a
Consideration But
It Will Be
Secondary . . .

transplantations represent clinical medicine. It says plainly it is research. It emphasized the difficulties and hazards such as the body's drive to reject a foreign organ; complications of using heavy doses of immunosuppressive drugs; the difficulty in finding donors with healthy, undamaged hearts and lungs; need for speed of transportation and transplantation; and the selection of proper recipients—those judged to be dying and unable to be helped by any other means.

In spite of these hazards one of the patients heroically volunteered: "We'd still be in the trees eating bananas if we didn't try things. We've got to try, not just sit on our hands. If I die I want to leave my family . . . with the thought that at least Mom tried."

Unfortunately, not all patients would be so charitable in their remarks and the family might have different thoughts if and after failure occurred. The general public, with fires fanned by news media which thrive on exciting news and reporting controversies and failures, might rebel at such experimentation. This may or may not be related to a heightened critical consumer attitude—often touted as increased desire for humanism and more emphasis on ethics. But this really isn't that new.

Sister Theresa Peck, administrator of St. Vincent Hospital, Indianapolis, said in the 1981-82 issue of their *Hospital and Health Center Review* that the era in medicine when this philosophic attitude of more humanism developed and "society joined in the belief that specific things existed which were worth defend-

Part 3 will be presented next month.

Correspondence: Dept. of Family Medicine, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis, Ind. 46223.

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<sup>\*</sup> Bibler Professor of Family Medicine and Director, Undergraduate Family Practice Education, Indiana University School of Medicine.

ing," was about the year I400 during the Renaissance. She thinks this type of thinking has prevailed and that people seem to say, "Don't tell me your problems. Tell me how you are going to better take care of me . . . today people do not hold health care sacred. Today, health care is perceived by many as that to which they are entitled."

It would be nice if we in the health care delivery system, whether it be physicians, nurses, technicians, administrators, manufacturers of equipment or pharmaceuticals, were all broadminded and fearless and could not only accept but encourage constructive criticism. But it isn't so. We may say we welcome it but many of us not only fear it but ignore it. We may even be vindictive to those who offer it. We should not equate every criticism as a personal attack that must be resisted.9

Criticism will become more plentiful in the area of experimental medicine. It's not an ordinary customer relationship. In an ordinary situation 96% of the dissatisfied customers do not complain to the person with whom they did business: and between 65 and 90% of these simply will never return to do business with the individual again. The guilty businessman or company has no idea what went wrong and has no way then to correct it. However, when customers do complain, 54 to 70% of those complaining can be won back with resolution of the problem. The businessman's key is to seek out complaints.9

In experimental medicine with humans, reasons for failure are known by the provider as well as the recipient. This is a mixed blessing. It is easier because, as I mentioned earlier, one knows what doesn't work and can eliminate that step and go on to try another. It is harder for the obvious reason that the failure has occurred with a human life.

Milestones in medical progress have been reached through experimentation with humans. Let me tell you about one that would now be an impossible study. In 1796, a British physician, Edward Jenner, asked himself, "Why do milkmaids have nice complexions?" He deduced that since all milkmaids had at one time or another had cowpox which must have protected them from smallpox, thus they did not have the big pockmarks of smallpox. He gave cowpox from the hand of a milkmaid to a 7-year-old boy. In a few weeks he tried to innoculate the boy with smallpox but the boy did not come down with it. This simple experiment undoubtedly saved millions of lives just as many future but yet undone experiments can save millions more.

The question follows: Can real progress be made without trials on humans?

I suspect great strides can continue to be made in preventing three of the five leading causes of death today without human experimentation but I doubt the other two can. The two where it will be needed will be in cancer and heart disease while shamefully two of the other three leading causes of death can be corrected with simple use of common sense and caution. These two are accidents and homicides with suicide being the fifth and questionable one. To a degree, at least one type, cancer, can be reduced with common sense and caution since the most frequent cause of preventable cancer is eigarette smoking.

Violence then dominates the leading causes of premature death. Society, to include the church and medical profession, has been unable to deal successfully with it.<sup>10</sup>

As an interesting "aside," Indiana University's physician-in-chief at Riley Children's Hospital, Dr. Morris Green, recently remarked that adolescent health is a quiet emergency. Between 1960 and 1979 the adolescent mortality rate rose 7½%. Fifty thousand teenagers die annually in the United States. But during that same 20 years, death rates for all other age groups went down significantly. In fact, the Office of Health Research, Statistics and Technology of the H.H.S. Department reported that for all ages the percent of change in ageadjusted death rates per 100,000 population for the years 1960-1977 was a reduction of 19.5% but for ages 15 to 19 there was a 10.2% increase and for ages 20 to 24 an 8% increase. Dr. Green has been named the project director for a four-year grant to the Indiana University Teaching Hospitals and the Marion County Health Department for \$600,000 from the Robert Wood Johnson Foundation to study this problem and find ways to make more accessible health services for adolescents. Causes of this increase in death rate are suspected to be violent deaths, unwanted pregnancies, alcohol and drug abuse, sexually transmitted diseases and mental illness.<sup>11</sup>

Of the leading causes of death just mentioned, heart disease is the one in which experimentation can be the most helpful. Mortality from heart attacks has decreased an unbelievable 25% in the last 10 years. Part of this obviously is due to more attention to and better treatment of hypertension, improved diet, more exercise regimes and perhaps less smoking; but increased heart surgery for coronary and valvular diseases, use of pacemakers and other exotic devices also have played a big part and I believe are destined to play a bigger part. In fact, the field for more improved gadgets is wide open. It is exciting but along with the use of these come the questions I've just asked relative to using them experimentally.

Let's talk a little more about prices. The costs for any hospital treatment is high but it is soaring for heroic types of treatment. Daniel Haney, an Associated Press writer for the *Journal American* wrote:

"Americans spend \$287 billion a year for good health. But are they getting their money's worth? On the face of it there is no need to ask. From university medical centers to rural clinics, costly 'medical miracles' of a decade ago have become workaday routine, improving thousands of lives. Cripples walk on man-made hips; bad hearts pump with fresh, new arteries; once doomed kidney patients survive on machines that cleanse their blood." But his article deals with rising and astronomical costs and he asks then, "Have soaring costs brought us close to the time when we will say: 'We cannot afford to keep this person

alive.' ''8

One possible solution would be simply to prohibit the heroic all out type of care to the hopelessly ill. But who's to decide if it is truly hopeless and could anyone with a conscience ever allow anyone to die without attempts to keep them alive? Should cost only be the deciding factor on who will certainly die and who might live if all out treatment were given?

Daniel Callahan, a philosopher and director of the Hastings Center in Hastings-On-Hudson, New York, says, "Certainly there is ample precedent in other countries for establishing limits on services and it's not hard to think it's going to happen in this country."

Dr. Thomas Chalmers, dean of Mount Sinai Medical School in New York, asks the important question: "What will happen when we wake up to the fact that we cannot afford to keep disabled, crippled, mentally incompetent and overaged people around? That day is to be as much dreaded as the loss of political and individual freedoms under any total-itarian government."

In spite of Dr. Callahan's statement, I do not think people's conscience will allow them to prohibit the use of any available medical technology just because it is expensive. And as Daniel Haney said, "The question is critical because medical technology is keeping a growing number of people alive—and fueling much of the increase in health care spending."

In my judgment, there will be lots of screaming and yelling and protesting of expenses, but people will not abandon any ill person. I believe they will yield to using more of their gross national product for health purposes. After all, what's more important than one's health? Certainly not so many of the material things in life. The emphasis will shift from how expensive it is to how to find ways to finance these extraordinary lifesaving and healing methods. Dr. Peter Budetti of the Health Policy Program at the University of California in San Franciso said: "Our general feeling is that it's not ethical to make life-or-death decisions based on economic factors."8 We're on the frontier and there will be mistakes, but doctors have been educated to and the public is expecting the single standard of medical care that Dr. Silk mentioned and that is the very best; the ethics of our society shall prevail and cost will be a consideration but it will be secondary.

There are groups grappling with these problems that could possibly shape the policies of government on the way health care is delivered. One is the Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. It was created by President Carter in December 1979 to continue the work started in 1974 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. It closed shop in 1978 and its work was continued by the Ethics Advisory Board in the old H.E.W.

These three groups have studied questions of if, when, and how to stop lifesustaining treatments, when is a person dead, if and how to oversee genetic engineering, what is adequate level of health care and who should provide it, to name a few.<sup>12</sup>

Morris Abram, chairman of the commission, said: "There was no other authority (in government) that could have performed this function. Every question we address grows out of the fact that medical science has advanced enormously. You always knew when a person was dead until respirators were developed."<sup>12</sup>

The March 21, 1983 issue of the *Indianapolis News* carried the A.P. story of another far-reaching statement by the same commission and announced by Morris Abram. Essentially, the report stated that the patient, if mentally competent, has the right to end life-sustaining therapy or to forbid heroic resuscitation efforts in a crisis even if an earlier death could be the consequence. Patients should make the decision but, in the event they are incapable, then the family should have the authority to decide.

The Abram Commission studied the

issue for two years before saying: "The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken."

The 11-member congressionally appointed commission was broad-based and included the fields of Medicine, Law, Theology, Ethics and Consumer Advocacy. It said that the central ethical concerns upon which decisions to treat or not to treat should rest on: "Is the burden imposed by treatment disproportionate to the benefit expected, and what are the patient's wishes?"

The report said law-making bodies and the courts generally should stay out of medical decisions, except in extraordinary cases where the wishes of patients or their representatives cannot be resolved with those of health professionals or hospitals.

"Doctors and hospitals are responsible for clearly outlining the treatment options available and their consequences, and for assisting patients in making the decisions that are in their best interest," the report said. "Health care professionals serve patients best by maintaining a presumption in favor of sustaining life."

The commission also recommended that hospitals and nursing homes establish ethics committees to review critical decisions and even have the authority to overrule parents or other non-patient decision makers in the event they disagreed with the decision.

"Experts estimated there are 5,000 permanently unconscious patients in the United States, so afflicted because of accident or illness," the report said. "The law should not require that particular therapies be applied or continued, except for basic nursing care, leaving these decisions to their families or representatives."

"... For almost every life-threatening condition, some intervention can delay the moment of death," Abram said. "Furthermore, dying no longer takes place at home—about 80% of Americans now die in hospitals or nursing homes.

"Since dying has ceased to be a private

affair and now involves these institutions," he said, "it has been complicated by involving many more people."

"Many of the hard decisions about possibly foregoing therapy could be resolved if people developed their opinions before getting sick," the commission said.

St. Vincent Hospital and Health Care Center of Indianapolis published an interesting article<sup>13</sup> which said:

"As Shakespeare's King Lear says over the body of his daughter, 'I know when one is dead and when one lives . . .' The only tests for life he had were to see if her breath would stir a feather or fog a mirror, and the only life support he could offer was to hold her in his arms. In today's hospital the tests for life may take 24 hours, and the decision of whether to institute heroic efforts to save the near dead or dying patient is posed to physicians, family, and friends who once had no choice. Several courts have struggled with that question and have come up with diverse results. It is clear that a competent patient may refuse medical treatment even when that treatment may be potentially life-saving. Pope John Paul has indicated that heroic measures in the face of unavoidable death not only are not morally required, but may be repugnant. The courts have agreed that an incompetent patient does not lose the right of self-determination because he or she is incompetent and cannot exercise it. In that case, another person may exercise it for the patient. The courts have split over who that substituted person should be and how he or she should be chosen . . ."

The *Indianapolis News*<sup>14</sup> said, "The so-called 'living will' which outlines a person's wishes about sustaining his life in case of later incompetency, is not legally binding in most states. But the commission recommends an alternative legal approach called the durable power of attorney. This authority to appoint a proxy to act after a person becomes incompetent exists in 42 states and could be used for making binding health care decisions."

Warner Lindau, a Miami cardiologist,

in testimony before the commission, said that there was a need for better understanding when it is appropriate to let "helpless, hopeless patients" die in peace. He said he "used to let more people die in peace than I do now," but "now I think frequently . . . what would look best before a jury? And this unfortunately interferes with doing what's best for the patient." He also raises a couple of interesting questions. Do we stop struggling to extend life "after we spend \$10,000, \$50,000 or \$100,000?" Alexander Capron, director of the commission, admonished that it is important for society to get this issue of life sustaining treatment straight before it gets enmeshed in economic issues."12 It is already at least peripherally enmeshed, for the health care financing authority of H.S.A. has come out with statistics that 11% of every year's Medicare expenditures are spent on those in the last 40 days of their life; 23% in the last six months and 30% in the last year. It is obvious that a great deal of this is for heroic last-chance efforts to prolong life; however, we must question whether it is prolonging life or prolonging the act of dying.

The commission, in a controversial recommendation, said: "When therapies are expected to be futile . . . reimbursement sources need not pay for them." And from a source of payment, Donald A. Young, deputy director of the Health Care Financing Administration's Program Policy Bureau, said: "We reimburse for the use of a resuscitatior, but the physician in charge decides when to use it." 12

I cite these examples to show the pressures that can be placed on a physician in such life-and-death decisions and when to, or whether to, use any exotic or experimental devices.

As I have mentioned many times, the practice of medicine and physicians' lives will change immensely over the next few years. The whole health care industry—every health care provider—will be affected. One of the main causes is the cost of medical care. Predictions are for more emphasis on prevention, more "do it

yourself care" with doctors simply consulting with the patients and advising them, more corporate and group practices to control costs better and as a result less intimate doctor-patient relationships will exist.

Competition in the development of new devices will increase. It will increase because of profits and publicity which has not all been good, especially as concerns original costs and mark-ups by intermediaries and end-users of the product. So, a competitive price soon will not only be a consumer expectation but also a watch-dog government's demand. As competition gets greater, those companies and agents that show sensitivity to the consumer and work together will be most apt to survive.

James R. Ridley, president of Integon Life of North Carolina, in an address before Life Comm User's group, a national cooperative computer system organization, suggested that companies will need a "survival kit" to survive threats to their business. These threats are inflation, negative consumer attitudes and non-traditional competition. To a degree, this advice fits almost any industry. He said the survival kit should include a ballot to elect government officials who are economically literate, a mirror to look at ourselves and determine if our actions are in the best interests of the consuming public, a computer to assist in meeting new demands and to help lower product costs, and a bucket of ice water, not to quench thrist, but to keep us awake.15

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#### The Otologist's Approach to Vertigo

JERRY L. HOUSE, M.D. Indianapolis

IZZINESS AND VERTIGO are very common complaints. Vertigo is a true sensation of motion. The patient will say things are spinning or that the walls seem to move. They may feel they are falling. Most patients with true vertigo will have a primary otologic cause for their symptoms. Patients with non-specific dizziness often describe a floating sensation or lightheadedness. The purpose of this paper is to help physicians make an accurate diagnosis when presented with these often confusing symptoms.

The first and most important step in making a diagnosis is taking an accurate history. Most of the information needed to make a diagnosis in patients with dizziness may be obtained from the history. The patient is asked to describe his sensation without using the word dizzy. The patient will either describe a sensation of movement or spinning, or perhaps a feeling of lightheadedness or floating. The former two symptoms are more suggestive of vertigo while the latter are more suggestive of metabolic or stress related problems. A history is obtained of the frequency and severity of the dizziness. Most vertigo of otologic origin occurs in discreet spells. The patient is usually free of vertigo between attacks. Constant dizziness that persists longer than six weeks is not caused by the ear.

It is now important to elicit a history of any associated central nervous system deficits with the dizziness. Loss of vision, syncope, or cranial nerve deficits are very suggestive of brain stem disease. Slurring of speech, weakness of arms or legs, or numbness of face or extremities also suggest brain stem disease. A diagnosis of vertebro-basilar insufficiency should be made with great caution if vertigo is the only symptom. Loss of consciousness does not occur as part of an isolated inner ear problem, no matter how severe.

The physician now needs to know if there is a hearing loss. Is it unilateral or bilateral? Does the hearing fluctuate in either ear? Is there ringing in either ear? Is there a sensation of pressure or fullness in either ear? If the answer to any of these questions is yes, one would immediately begin to think of an otologic cause. Otologic vertigo often causes nausea, vomiting and diaphoresis.

#### Otologic Causes of Vertigo Associated with Hearing Loss

Patients with episodic vertigo associated with a fluctuating hearing loss are very suspect for otologic disease. This is often associated with ringing in the ear and can be associated with pressure in the ear. These patients should be examined serologically with a F.T.A. to rule out otologic syphilis. A sed rate should be obtained to screen for autoimmune inner ear disease. The diagnosis of Meniere's disease is now reserved specifically for the clinical triad of fluctuating low tone hearing loss, episodic vertigo, and tinnitus. This is often associated with a sensation of aural fullness or pressure. There is no associated neurologic deficit. The patient is free of vertigo between the definitive

Those patients with vertigo and a non-fluctuating or progressive hearing loss present with different diagnostic possibilities. A sensation of imbalance associated with poor speech discrimination in one ear is very suggestive of an acoustic neurinoma. Any patient with a unilateral hearing loss, particularly if

associated with poor understanding for speech or poor discrimination on the telephone should be highly suspect for an acoustic tumor. Dysfunction of the vestibulocochlear nerve should be treated as any other neurologic sign and deserves proper evaluation. It is common in my practice to see patients with large acoustic neurinomas who have had an "unexplained" unilateral hearing loss a year or two before.

If the patient has drainage from the ear and a conductive hearing loss, the ear should be examined carefully for cholesteatoma. This will present with purulent drainage and a defect in the tympanic membrane. Cholesteatoma can produce a horizonal semicircular canal fistula and subsequent vertigo. The cholesteatoma must be treated promptly if the hearing is to be preserved.

Glomus tumors of the temporal bone commonly present with hearing loss, pulsatile tinnitus, and dizziness. They can be seen as a red mass behind the tympanic membrane, or they can grow out the ear canal. If glomous tumors involve the jugular bulb they may not be seen behind the tympanic membrane and may require radiographic studies for diagnosis.

Trauma to the ear can cause dizziness as well as conductive hearing loss. The dizziness will usually take the form of benign paroxysmal or positional vertigo. Herpes zoster otitis or the Ramsey-Hunt syndrome can cause acute vertigo. Herpetic vesicles on the outer ear or the lateral surface of the tongue can be seen. This is often associated with severe pain in the ear and facial nerve paralysis much like Bell's palsy.

Otosclerosis is a very common cause of correctable hearing loss occurring in the younger age group. It can uncommonly cause vertigo. If the family history is suggestive, and conductive hearing loss is present, the vertigo may be related to

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Correspondence: 9102 N. Meridian St., Suite 525, Indianapolis, Ind. 46260.

otosclerosis. Medical or surgical therapy may be offered to help these patients.

Sudden vertigo following straining, flying or scuba diving is suggestive of perilymphatic fistula. This is a leakage of fluid from the inner ear caused by sudden pressure change. Surgical exploration and repair of the leak may be indicated to eliminate the vertigo and preserve the hearing.

#### Otologic Causes of Vertigo Not Associated with Hearing Loss

There are two common clinical syndromes that present with vertigo that are not associated with hearing loss. The first is vestibular neuritis or viral labyrinthitis. This presents as an acute episode of severe vertigo associated with nausea and vomiting. These patients are often bedfast for a few days and then will have motion intolerance and residual vertigo for several weeks or months. The hearing remains normal and there are no neurologic deficits.

The second common cause of otologic vertigo with normal hearing is benign positional or paroxysmal vertigo. This can be seen at any age but is common in the older patient. It is also very common after head injury. The patient will complain of severe spinning vertigo upon going to bed or rolling over in bed. The vertigo is usually short in duration and can be associated with nausea. This type of vertigo is always related to head movement and is usually self limiting.

#### Non-Otologic Causes of Dizziness

There are many central nervous system disorders that can cause vertigo. It is not the purpose of this paper to describe these fully, but they should be in the differential diagnosis. Many of the circulatory disorders involving the brain stem can cause dizziness and vertigo. There is almost always an associated neurologic deficit. This may take the form of visual black outs, syncope, or cranial nerve dysfunction. Normal pressure hydrocephalus can cause imbalance, dementia, and incontinence in the older patient. Vertiginous epilepsy is uncommon but also can be the cause of spells of vertigo. Multiple sclerosis should be considered in the younger age groups.

Tumors in the posterior fossa are commonly associated with imbalance and usually will present with a hearing loss as described above. These tumors rarely present with acute vertigo unless the blood supply to the inner ear or brain stem is suddenly altered.

Metabolic problems can exacerbate balance disorders. Hypothyroidism is a known cause of vertigo but unless severe, it will usually not be responsible for the vertigo. Reactive hypoglycemia is another well known cause of dizziness.

Many other patients will complain of vague balance symptoms described as floating or lightheadedness. They often feel faint. If the hearing is normal and there is no associated neurologic deficit,

several possibilities should be considered. Hyperventilation or stress problems should be considered in this group of patients. These patients are best managed by supportive therapy and are requested to keep a diary of things that exacerbate their dizziness. An attempt is made to eliminate as many of these environmental or stress factors as possible to reduce their symptoms.

#### Physical Examination of the Dizzy Patient

Physical examination of the dizzy patient is often unrewarding. One should specifically do a complete otologic exam to visualize any abnormality such as infection in the ear, tumor, or cholesteatoma. A complete cranial nerve examination should be done. Cerebellar testing with gait and station testing is also performed. A complete neurologic exam is done as indicated. If seen during an acute episode of vertigo, nystagmus should be seen. An audiogram is routinely obtained. Special diagnostic tests may include an electronystagmogram (ENG), CT scan, or evoked potentials.

It is impossible to give a complete review of all causes of dizziness in such a short space. It is hoped that the preceding tips will help the primary care physician with his diagnosis of vertiginous disorders. Appropriate medical or surgical therapy can often help the patient with an otologic cause for his vertigo once the offending ear is identified.

## **Epidemic Inflammatory Disease of the Bronchial Tree with Systemic Effects**

WARREN N. McCLURE, M.D. Kokomo

FEEL A COMPULSION to write about a disease that is filling my office, because I've found a method of cure that is gratifying. Perhaps you already are aware of all of this.

I have noted in my practice since November 1982, a steady stream of consistent physical findings with differing complaints. All of these people show three findings: (a) an inflamed throat, sometimes streaky red, sometimes completely flushed and swollen, and occasionally with tonsillar exudate that does not appear like Streptococcus infection; (b) secondly, they all have unequal breathing; they present either a lag on one side or the other. This is definite. and when another person is in the exam room, such as a nurse, or the spouse, or another relative they can see it; (c) thirdly, the person shows on percussion a definite dullness on the side of the lag. This, too, is extremely definite, appreciated by any that are in the room. Percussion has to be gentle to pick up the dullness and must be done correctly. It should be done with one finger on the chest wall and very carefully avoiding any part of the hand touching the chest

I've noted all degrees of disability with these findings. Some are very sick with high fever, some mildly sick and some claiming no sickness at all.

Complaints vary. Most have had a sore throat and are coughing, but some show no obvious cough. Almost all complain of tiredness, which is very real. Headache is not uncommon and

The author is a diplomate of the American Board of Family Practice.

Correspondence: 319 S. Berkley Road, Kokomo, Ind. 46901. sometimes very severe, and two cases have shown increase of WBCs in a spinal tap. Abdominal complaints are frequent, many times with outright diarrhea. Otitis is not uncommon either, with occasional blister on one drum. Chest pain is present in many and sometimes is on the opposite side of the lag and dullness. Fever is not consistent. It may be high, but most do not show elevation.

This is a family disease. When one member has it, one can assume that all members have it, particularly if the family is close-knit with a good deal of mouth kissing. Obviously, the disease is very contagious. I've seen one family of 27, all of whom had the disease process. I think it takes about five days to manifest the disease after exposure.

Attempts at a definite diagnosis have been without success. Mycoplasma complement fixation has been negative—culture of the throat nunely shows a strep. Viral panels have been negative. CBCs tend to show a low total white count with a depression of lymphs, but this is not in every case. Hematuria has occurred in three cases. Chest x-ray is usually negative. If the person has had the disease a long time and suddenly gets very sick, an infiltrate can be identified in the x-ray. I think that this is an unidentified virus infection, but secondary bacterial infection can occur.

My most interesting case history involves a pregnant girl and her newborn. I was notified of the delivery and was told that the placenta was very odoriferous, and that the baby also stank. The obstetrician took cultures of the placenta and of the baby's orifices and also did a blood culture. I saw the baby at about four hours. I found the red throat and discovered a definite dullness in the right chest. I showed the Registered Nurse the dullness and she heard it. Then I went to the mother and found her to have the same findings—a

red throat, a lag on the left, and dullness on the left. She told me she'd had a "cold" for the past two weeks, and still felt bad. I showed the R.N. on the floor her definite lag and dullness. She agreed.

Treatment has evolved over the past year and a half and still may change. There is no question that if this entity can be recognized quickly, it can be eliminated from the chest in 12 hours. This is by postural drainage and forced coughing, producing the yellow, thick substance that must fill the bronchial tree (see the postural draimage chart). When the condition is not recognized, the disease state can worsen and high fever may occur. Then an expectorant plus either Doxycycline or Erythrocin have been used, allong with postural drainage at home. Some people are hospitalized. I usually only hospitalize those who cannot do successful postural drainage, or who have serious systemic illness that the disease state is complicating. The Emergency Room also tends to hospitalize many with the disease. They are admitted with many diagnoses-appendicitis, heart attack, acute gastritis, acute cytopyelitis, etc. Patients hospitalized are treated with respiratory therapy. This is ordered as updraft with Bronkosol .25 cc. t.i.d., followed by assisted postural drainage and cupping of the "dull" side. Usually a person will clear in three days. I've taken five to seven days with only the most disabled. I emphasize that most can get well at home by postural drainage and coughing up the infectious

I think it is very important to discover the disease. It is easily treated, and it is a contagious disease. Even people who are tolerating it mildly still are contagious and should be rid of the condition. I've found families tend to have this disease for months if all do not get well at one time.

Babies and old people handle the disease the worst, probably because they cam most successfully do postural drainage. I don't know how long this disease would persist without treatment. I'm relatiively sure that it has been in some chests from six months at least. I don't know iff there would be long-term bad efficients from mot getting the material out off the chest, but I can imagine that filbrossis off that region of the bronchial trace could occur.

I feed that it is a worthwhile effort to fiind this entity. Flu?—check for lag and dullmess. Strep throat?—check for lag and dullmess. Emcephalitis?—check for lag and dullmess. Chest pain?—check for lag and dullmess and realize that coronary disease can exist with the inflammatory bromchial disease. Abdominal pain?—check for lag and dullmess. Mononucleosis?—check for lag and dullmess. You may already be seeing the entity, but if not, really practice careful meticulous exam of throat and chest expansion plus careful percussion. It could simplify some of the situations in your office.

Very active young people apparently cam get well without treatment or draimage, but it probably takes a few weeks. I'we seem one elderly patient with chromic involvement get "well" without specific treatment and with only quietness and bed rest. Most, though, get worse and show more involvement under similar circumstances.

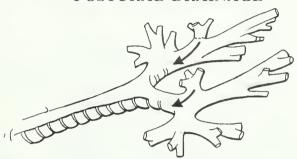
I thimk this disease is, umdoubtedly, matisomwide. In one single day in the office, I saw a person who recently came from Alaska with the disease. (She said that her doctor said he had seen this triad of symptoms in his town in many people.) The same day I saw a person who came from Florida two days earlier and she also had the typical fundings.

Good luck in funding this disease and curing it. I feel that if more doctors would diagnose this disease, we might possibly be able to remove it from our area.

#### REFERENCE

Pencussion. Im *Physical Diagnosis*, by Prior, Silversteim and Stang, pp 2013–2017. C.W. Mostby Co., St. Louits, 1981.

#### POSTURAL DRAINAGE



Epidemic inflammatory disease of the bronchial tree (above) can be eliminated from the chest by postural drainage and forced coughing. A person with this disease, which can be passed by close contact such as kissing, is usually contagious for three days. If a baby (or uncooperative child) is involved, the mother should place the baby on her lap with its head and chest down and then tap lightly on the back. A mask is necessary in every contact; such household items as a washcloth or hand towel can be used as a facial mask but to be effective should not be worn more than 15 minutes.



Two positions—above (for patients incapacitated by age, illness, etc.) and below (for persons able to achieve the position)—demonstrate methods used to expectorate phlegm. Such exercises should be done for two days. On the first day, the exercise should be performed at least eight times, coughing each time for one-half to one minute. Fluids should be encouraged during the treatment, and the best time to succeed in getting up the bronchial secretion is immediately after meals. On the second day, the exercise should be performed after meals and at bedtime.





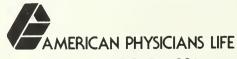
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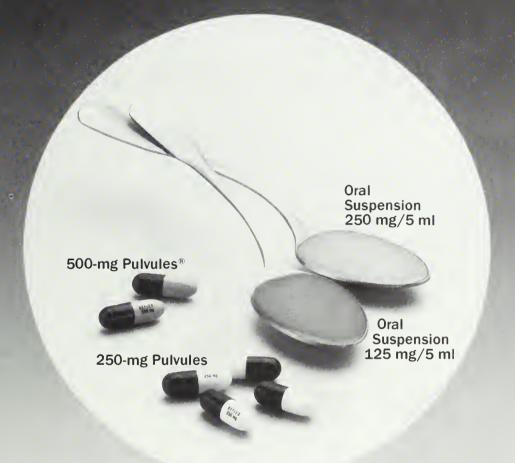
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#### The Wright Institute of Otology

#### Midwest Pioneer in Hearing and Ear Research

GEORGE W. HICKS, M.D. Indianapolis

N 1960 THE FIELD of hearing and ear surgery was growing out of its infancy. New techniques of ear surgery were being perfected. Innovative methods of solving the problems of ear disorders were being developed. It was at this time that a non-profit scientific, educational, and research facility was established in memory of Dr. J. William Wright, Sr., a prominent Indiana otolaryngologist. Called The Wright Institute of Otology, this organization was initiated for the purpose of promoting research into the cause and treatment of ear disease and to increase an understanding of the manner in which the human ear performs. The Institute does not engage in the "practice" of medicine.

#### Clinical Research

Over the past 25 years, The Wright Institute of Otology has grown in size and scope. Presently it is directed by a Board of 25 civic and business leaders. There is also an Advisory Board composed of prominent Indiana physicians with interest in hearing and balance problems. A nonprofit organization affiliated with Community Hospital of Indianapolis, the Institute is funded by grants and donations from various foundations, hearing organizations and contributions from corporations and individuals. Under the guidance of Dr. J. William



HELP THROUGH EAR RESEARCH

Wright, Jr., Dr. J. William Wright, III, and Dr. George W. Hicks, several areas of clinical research have in the past or are presently undergoing investigation.

- 1. Temporal Bone Lab. One of the first projects of The Wright Institute was the establishment of a laboratory for the study of the temporal bone. Here, sectioning techniques were developed and experiments made with plastics to preserve the temporal bone sections. Laboratory experiments proved invaluable in researching other areas and led to improved surgical techniques and reconstruction of anatomic models. These facilities were also used for the training of Indiana University Otolaryngology residents in their study of ear diseases and surgery.
- 2. Polytomography. Another important accomplishment of the Institute was the development of multi-directional polytomography in the study of temporal bone disease. Papers on these findings were published in national and interna-

tional medical journals. These studies led to an exhibit at the North American Roentgenology Society which awarded it the Magna Cum Laude prize. Interest in this subject led to the establishment of an annual course in tomography of the temporal bone. To this course have come radiologists, neuro-surgeons, neurologists and otolaryngologists from around the world in order to receive instruction in the technique and interpretation of these special x-rays.

- 3. Meniere's Disease. The role of the endolymphatic duct in the predisposition or cause of Meniere's Disease is undergoing intensive study at The Wright Institute. Also being investigated is the possible role of allergy in this inner ear disorder. In conjunction with Dr. I. Kaufman Arenberg of the Colorado Ear Institute, the use of a specialized inner ear valve which helps control this disease's symptoms is being presently evaluated.
- 4. Ceramic Implants. The Institute has been utilizing various forms of ceramic implants, particularly calcium-aluminum suboxylate in the temporal bones of monkeys. These implants have been in place for over eight years and have shown to be well tolerated. Further observations regarding these implants continue.
- 5. Computerization of hearing aids. In cooperation with the Central Institute of the Deaf in St. Louis, Missouri, The Wright Institute is engaging in a national project which utilizes modern computer technology in the selection and fitting of hearing aids.
- Multi-electrode cochlear implant.
   The Wright Institute is one of five investigative organizations selected by the

From the Wright Institute of Otology, Inc., 1500 N. Ritter Ave., Indianapolis, Ind. 46219.

University of California at San Francisco to be part of the first United States group utilizing the multi-electrode cochlear implant, the only United States implant presently known which improves the ability of the deaf to understand speech.

7. Cochlear dimensions and noise induced hearing loss. The possibility of a relationship between the length of the cochlea and susceptibility to neurosensory hearing loss from loud noise exposure is presently being evaluated.

#### **Education**

Realizing the need for an increased education and awareness of hearing problems, The Wright Institute has initiated various educational programs for medical personnel and the general public.

1. Primary Care Course in Otology. An annual course is given to primary care physicians dealing with common office otologic problems. These one-day seminars have been helpful in improving the care received by the public at their point of entry into the health system.

Also of benefit in the education and training of medical personnel are the films and slides of clinical ear surgery. These educational devices are made available to physicians, residents and paramedical personnel. These aids are made possible through the use of a microsurgical camera on the operating microscope which was purchased by The Wright Institute.

- 2. Industrial Noise Seminars. Seminars are held on industrial noise to assist industry in training their personnel to meet government regulations on noise pollution. The staff has also acted as advisors to industry on specialized noise problems.
- 3. Hearing Fair. The Wright Institute initiated a unique educational project to increase public awareness and education regarding hearing disabilities. The first Hearing Fair, held in October 1981, was attended by over 50,000 people and received the CASPER Award from the Community Service Council of Indianapolis for its contribution to the



 $\label{thm:control} \textbf{THE WRIGHT INSTITUTE OF OTOLOGY gives an annual course to primary care physicians on common office otologic problems.}$ 

public welfare. Not only is this a biannual event, but it has served as a prototype for similar fairs all over the country.

- 4. Hearing Dog Program. In cooperation with the Indianapolis Humane Society, a Hearing Dog Program is being developed as an asset and assistance to the hearing impaired.
- 5. Free Hearing Tests. Free screening-hearing tests are given at various public locations throughout the year, including senior citizen centers, children's homes, shopping centers, etc..
- 6. **Speakers' Bureau**. The Institute's physicians and staff have appeared before the media and civic and educational organizations to educate the public in the prevention, cause, treatment and rehabilitation of hearing problems.
- 7. **Better Hearing Institute Affiliation**. The Wright Institute is one of 27 organizations in the United States affiliated with the Better Hearing Institute

of Washington, D.C.. They serve to inform the public about hearing problems and sponsor a combined national public education effort, Better Hearing and Speech Month, every May.

8. Otolog Newsletter. A quarterly newsletter is published by The Wright Institute regarding hearing problems and other related questions. It is sent to medical and paramedical personnel as well as lay individuals and organizations throughout Indiana and adjacent states.

The Wright Institute of Otology, Inc., as an affiliate of Community Hospital of Indianapolis, continues its research and educational functions through the dedication, time, and financial support of many people. In the next quarter century of its existence, the staff, directors, advisors, volunteers and contributors hope to further expand the knowledge of hearing problems and continue to serve both the hearing and nonhearing community.

#### Licensure and Incompetent Practitioners

#### A Message from the Executive Director

HE INDIANA STATE Medical Association has expressed its concern about the false impressions that may have been created by recent newspaper articles citing from Congressional Records a physician who is licensed to practice in Indiana, despite having lost his license in 10 other states. The issue was precipitated by recent testimony given before the U.S. Senate's Special Committee on Aging concerning the issue of reimbursement under federal health programs for health care practitioners who lose, for cause, a license to practice in one jurisdiction and then relocate to another state where they also hold a valid license. Such actions by practitioners concern all professionals in the health care field since such practitioners discredit their professions and reflect unfavorably on state licensure programs.

State licensure has been and continues to be a major factor in assuring the high quality of health care available to all citizens. The General Accounting Office (GAO) which recently reported to Congress on this subject has discussed the matter with the American Medical Association. It is important to note here that the GAO in its report to the Congress uses the term health care "practitioner" to include Doctors of Medicine, Doctors of Osteopathy, Podiatrists, Chiropractors, Dentists, and Pharmicists.

Despite the sensational nature of the recent newspaper headlines regarding the incompetency of doctors, the public should rest assured that the vast majority of Indiana's physicians are competent. As a matter of fact, the Indiana State Medical Association and the Medical Licensing Board of Indiana have



DONALD F. FOY
Executive Director
Indiana State Medical Association

been working together to prevent incompetent physicians from practicing in Indiana. As a result, the following specific legislation and regulations have been enacted over the past several years to deal with this problem:

• Indiana law has been amended to provide that the Governing Board of a hospital shall report, in writing, to the Medical Licensing Board of Indiana, the results and circumstances of any final adverse disciplinary action taken by the Governing Board regarding a physician on the medical staff, or an applicant for the medical staff, if the action results in voluntary or involuntary resignation, termination, nonappointment, revocation or significant reduction of clinical privileges or staff membership.

- New rules promulgated by the Medical Licensing Board of Indiana and signed by the Governor require physicians who become aware of incompetent or impaired physicians to refer them to an organized peer review committee for treatment and monitoring. In addition, this information must be made available to the Medical Licensing Board of Indiana in the event satisfactory progress can not be made.
- Indiana law also provides that the Indiana Insurance Commissioner must forward the name of every health care provider, against whom a malpractice settlement is made or a judgment is rendered, to the Medical Licensing Board for review of the fitness of the health care provider to practice his profession.
- Indiana law also provides that a practitioner who has had his license suspended or revoked in another state can also have his license revoked or suspended in Indiana upon receipt of a certified copy of the record of suspension or revocation from the other state.

Great strides have been made in recent years regarding the identification, monitoring and control of incompetent physicians in order to prevent them from jumping from state to state. The Indiana State Medical Association supports the Medical Licensing Board of Indiana in its diligent efforts to ferret out that small number of incompetent physicians who hurt the entire profession.

Also, the AMA maintains a unique data base of licensed physicians called the "AMA Physician Masterfile." The Masterfile contains independently verified information on all physicians licensed to practice within the United States and includes information such as address, declared practice specialty,

medical education, graduate training, board certification, states where licenses have, at some time been granted, and a record of state licensure actions.

Moreover, the AMA has a long-standing policy of cooperation with state licensing boards seeking information from the AMA regarding disciplinary actions taken in other states. This is especially important in light of the fact that in many states revocation of a license in another jurisdiction constitutes grounds for sanction. In the past when the AMA received a request from a state medical board about licensure actions concerning a physician, that information was promptly provided. Unfortunately some states did not routinely take advantage of the AMA Masterfile informa-

tion. As a result, the AMA recently adopted a more aggressive procedure. When the AMA receives verifiable information concerning a license revocation. suspension or surrender for cause and when that action involves a physician's competency to practice, it will automatically notify the medical licensure boards of all states in which its records show the physician has held a license. The AMA will be conducting this activity as part of its professional responsibility and because its Masterfile provides what appears to be the only source of multi-state licensing information about physicians.

While the Senate Special Committee on Aging is particularly concerned with treatment of the elderly under federal programs, we believe it is equally important that the entire population is protected. It is, therefore, necessary for states to take prompt action concerning information regarding practitioners whose licenses are revoked.

In the case of license suspension or revocation for cause relating to medical incompetency in one state, we believe practitioners' exclusion from participation in Medicare and Medicaid is appropriate, regardless of licensure status in other states. The AMA and the ISMA would support appropriate federal legislation in this area. In our view, regardless of where a patient receives services or how those services are being reimbursed, no patient should be subject to medical care from an incompetent practitioner.

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#### A Liberal 'Ain't What He Used to Be'

#### Commentary

UDWIG VON MISES, the noted free market economist, once observed that only a central government could take two perfectly useful commodities—ink and paper—and, by combining them in paper money, create something totally useless. As a refugee who fled the political consequences of Germany's hyper-inflation in the 1920s, Von Mises' hyperbole may be excused. The point is made.

It is not easy to create nothing from something, to spin flax from gold or to turn a silk purse into a sow's ear. Few attempt it. It is sad that modern-day liberals have done just this to the once proud and honorable word "liberal."

Two centuries ago, liberals were at the forefront of the revolutionary struggles against the old order, the ancien regime, in Europe. They opposed the monarchies and supported republican government. They waged the intellectual battle against protective tariffs such as Britain's infamous Corn Laws. They stood in opposition to mercantilism, the theory which attempted to justify economic isolationism. Indeed, Adam Smith's The Wealth of Nations, the foundation of modern free market economics, was the product of this liberal movement. John Locke, a leading liberal theorist, laid out the case for limited government, arguing that government is best which governs least. He called for replacing the rule of individuals with the rule of law, and confining the legitimate scope of government to defending life, liberty and property.

In opposing the old aristocracies, the liberals believed in the equality of man before law and before God. Liberals led



RICHARD L. LESHER
President
U.S. Chamber of Commerce

the spiritual revolution that precedes physical revolutions.

Our American Revolution was the product of this liberal thought. Representative democracy, limited government, low taxes, free trade, freedom of religion, and the protection of private property were the foundation of the liberal movement in Europe and the goals of a tiny nation of three million pioneers who challenged King George III and the most powerful empire in the world.

Herbert Spencer wrote in *Man Versus* the State that "the function of liberalism in the past was that of putting a limit

to the powers of kings. The function of true Liberalism in the future will be that of putting a limit to the powers of Parliament." Something happened to the liberal movement that aborted this transition. The liberals ceased being advocates of limited government and individual liberty and became instead the champions of a strong and intrusive central government.

Where they once fought to remove the shackles on individual rights, liberals began to call for more restrictions on those rights. They no longer wished to control and limit government, but instead strove to control and limit men and women. Hence, the New Deal, the Great Society, the Welfare state, and countless bureaucracies and agencies were all created with wealth taken from the people. This was extolled as progress by liberals.

Classical liberals were appalled. Those who believed in the values of limited government rejected the word liberal and began to call themselves conservatives or libertarians. But the damage done to the word liberal was so complete that eventually even the big government types jettisoned the label of liberal. Big-spending politicians now avoid the word like the Black Death. "Call us progressive," they whine. Or try "compassionate." Anything to distance themselves from the consequences of their disastrous economic policies.

In Europe, the Liberal parties remain relatively true to the historical origins of the free market movement. There the high-tax, high-inflation, big-government politicians march under a more honest banner. They call themselves socialists.

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#### References:

- 1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
- Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exerciseinducible chronic stable angina with diltiazem: Effect on treadmill exercise. <u>Chest</u> 78 (July suppl):234-238, 1980.

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#### CLINICAL PHARMACOLOGY

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Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been

shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced cor-

and suberloocarioa. Sportinations and ergomovine-induced cor-onary artery spasm are inhibited by CARDIZEM. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward In animal models, dilitazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Dilitazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses

In man, diltiazem prevents spontaneous and ergonovine-provoked In man, dilitiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of dilitiazem and her belevers. Reverse have not been affected. of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

of slightly reduced by diffazem.

Intravenous diffazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diffazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus

with sick sinus syndrome, unitazen syndrome, vector engine for the cycle length (up to 50% in some cases). Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Dilitazem is absorbed from the tablet formulation to about 80% of a reference capsule and

is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl dilitizarem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as dilitiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given a 120-mg dose gave blood levels three times that of the 60-mg aven. given, a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem

#### INDICATIONS AND USAGE

Angina Pectoris Due to Coronary Artery Spasm, CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment

elevation occurring during attacks).

2. Chronic Stable Angina (Classic Effort-Associated Angina). CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.
There are no controlled studies of the effectiveness of the concomi-

tant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities

#### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

#### WARNINGS

Cardiac Conduction. CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of AV block (six of 1243 patients for 0.48%). Concomitant use or diffusizem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diffusizem.

Congestive Heart Fallure. Although diffusizem has a negative interest of the involved annual fission proposations between the proposations.

inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should

be exercised when using the drug in such patients. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic

Acute Hepatic Injury. In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. See PRECAUTIONS and ADVERSE REACTIONS.)

#### **PRECAUTIONS**

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In sub-acute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing **Drug Interaction**. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using the blood to the conduction when using the processing the studies and the second to the conduction when using the conduction w

beta-blockers or digitalis concomitantly with CARDIZEM (See

Controlled and uncontrolled domestic studies suggest that con-comitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times

There was an increased incidence of stillbirths at doses of 20 times the human dose of greater.

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing exercise caution when CARDIZEM is administered to a noresing internal if the drug's benefit are thought to outweigh its contential woman if the drug's benefits are thought to outweigh its potential risks in this situation

Pedlatric Use. Safety and effectiveness in children have not heen established

#### **ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%) headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%), in addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular Flushing, arrhythmia, hypotension, bradycar

dia, palpitations, congestive heart failure syncope

Paresthesia, nervousness, somnolence tremor, insomnia, hallucinations, and amnesia Nervous System Gastrointestinal Constipation, dyspepsia, diarrhea, vomiting mild elevations of alkaline phosphatase, SGO

SGPT, and LDH Pruritus, petechiae, urticaria, photosensitivity Dermatologic

Other Polyuria, nocturia. The following additional experiences have been noted

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARRIZEM.

The following postmarketing events have been reported infre-quently in patients receiving CARDIZEM: erythema multiforme, leu-kopenia, and extreme elevations of alkaline phosphatase, SGOT. SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established

#### **OVERDOSAGE OR EXAGGERATED RESPONSE**

Overdosage experience with oral diltiazem has been limited Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Administer atropine (0.60 to 1.0 mg). If there Bradycardia is no response to vagal blockade, administer

isoproterenol cautiously.

Treat as for bradycardia above. Fixed high High-Degree AV degree AV block should be treated with car diac pacing

Administer inotropic agents (isoproterenol dopamine, or dobutamine) and diuretics. Cardiac Failure Vasopressors (eg, dopamine or levarterenol Hypotension

hitartrate) Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating

physician. physician. The oral/LD $_{50}$ 's in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD $_{50}$ 's in these species were 60 and 38 mg/kg, respectively. The oral LD $_{50}$  in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity

#### DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atheroscierotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coro nary Artery Disease or Anglina Pectoris at Rest Due to Coro-nary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concern-ing dosage requirements in patients with impaired renal or hepatic function. If the driver must be used in exploations to transport. function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. Sublingual NTG may be taken as required to abort acute anginal attacks during CARDIZEM therapy.

2. Prophylactic Nitrate Therapy—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal

effectiveness of this combination.

3. Beta-blockers. (See WARNINGS and PRECAUTIONS.)

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

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#### EDITORIALS

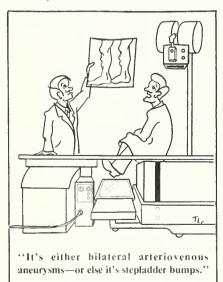
#### Ureteroceles

The following editorial refers to an article appearing in this issue's scientific section, "Riley Children's Hospital Ureteroceles: A 12-Year Experience." It begins on page 522.

The traditional therapy for ureterocele with duplication is supravesical excision of the upper pole segment because the ureter is diseased not only in position but also in histology.\* This was done in seven patients in this study. However, cystography demonstrated reflux in 12 of the cited cases and these obviously required considerably more surgical therapy either at the initial procedure or as staged events. Fourteen of the patients in this study had two or more procedures.

All of these facts are consistent with the accepted modes of treatment and also indicate the modern trend toward more extensive initial surgery and one stage excision of the ureterocele and duplicated kidney with or without reimplantation of the remaining ureter. Previously, this was considered dangerous because of the muscular bladder wall thinning associated with ureterocele, but newer reimplantation technique has minimized this complexity. Three of the cases here did have asymptomatic postoperative vesical diverticula, however. The paper

\*Kelalis PP, King LR, Belman AB: Clinical Pediatric Urology, W. B. Saunders Co., Philadelphia, 1976.



doesn't clarify whether more extensive initial surgery is more acceptable now than 12 years ago. I would guess that this is the case.

Bob Garrett and his senior authors have written a lucid, forthright and useful resume of the Riley Hospital 12 year experience with ureteroceles. They make the essential point that each case must be individualized particularly in an obfuscated embryological disorder such as ureterocole. A commendable effort.-Rodney A. Mannion, M.D., LaPorte, Ind.

#### Cream of the Crop Guest Editorial

There is a current stampede to set up Health Maintenance Organizations, or HMOs. Insurance companies, hospitals, and medical societies are spending hundreds of thousands of dollars for expensive administrative and sales help to merchandise prepaid health insurance. They think they can offer plans that will guarantee to look after the health of a man and his family for a fixed, prearranged charge per year.

In 1973, the federal planners passed enabling legislation for HMOs, committing millions of federal dollars as startup money for these new "alternative health care" methods. Ten years later, only 5% of the population was covered by that type of health plan—and many HMOs had gone bankrupt, both the subscribers and the doctors losing all they had invested.

The Kaiser-Permanente Foundation, on the West Coast, is the oldest successful HMO. It has done well by "cream-of-the-crop" patient selection, naturally preferring to enroll young and healthy workers and their families and avoiding those already old and sick.

Two years ago, the doctors in the Twin Cities area in Minnesota set up their own HMO in the form of an IPA (for Individual Practice Association). They wrote into their contract with the local corporations a relief clause that would allow them to collect an additional 10%, at the end of the year, if health care costs exceeded premiums by more than that amount. When they tried to collect the money (since every corporation in town had exceeded its budget except one), the Minnesota State Board of Health charged them with writing an illegal contract—and fined them \$7.500.

1 recently spoke briefly to the man who is setting up an IPA for the local medical society. I asked him how the association planned to protect itself from the abuses of the National Health Service in England; e.g., Grandma regards her visit to the doctor—since it costs her nothing—as a social event, and arrives with a new complaint each week. "Well," he said, "We may just have to disenroll Grandma." In other words, if we can just enroll the cream of the crop. . . . H.C. Moss, M.D., Indianapolis

#### Health Broker: **New Commodity Expert** Guest Editorial

We all know the auto dealer who gets on the phone—"Hey, Joe, I need a red convertible. Could you use a blue station wagon?"

"Don't worry, Mrs. Smith, we'll find you a good heart surgeon. Of course, anesthesia will be extra."

Sounds like a travel agent for the cruise lines. "Do you want A deck or B deck accommodations?"

With multiple listing agencies, just as in real estate, health brokers will split fees, commissions or trade services to divide the DRG pie, which is proposed to be limited by law.

Frightening—you bet. Today when the patient and the private physician decide on a course of care or selection of consultants or surgeons, there are certain ground rules of ethics that apply. Economic factors are evident today. If a physician is in a large group, referrals will occur within that group when possible, but the patient knew and accepted that upon entering such a care system.

Individual physicians refer in similar patterns, but hopefully, as patient advocate primarily, he seeks the most appropriate source of care. He does not participate in the fees; his reward is the results of successful treatment.

With lump sum allocations for total care, the health care providers will become shoppers for bargain services.

Rather than call consultation early, the doctor may tough it out. He'll get the total fee whether the case ends in good results or not. Primary doctors will negotiate with surgeons for procedures based on price rather than skill, convenience, efficiency or concern for lost time.

Hospitals may offer incentives to admitting physicians in order to attract business away from competing hospitals.

The patient continues on as the pingpong ball, with everyone batting at him and not for him, except his broker, his travel agent for health, or his dealer with the low sticker price who now replaces his doctor to act in his behalf for a fee.—C. Dyke Egnatz, M.D., Schererville

#### New Models Needed for Health Care

Guest Editorial

As one views the situation in our health care system, you can't help but feel it's time for hospital administrators and physicians to meet and decide what model for health care they would like to be used. We have discussed the impact on health care of the coming glut of physicians and other health care professions.

From a casual reading of news media, it would appear that government, big business, and insurance companies believe

that we have a Cadillac system when we should be driving a Chevy. Those of us in the health care field are reacting to changes instead of planning ahead and implementing a course of action to solve the problems. We appear to be so busy providing health care and looking after the patient that we are losing control.

It reminds us of the situation where a subdivision was opposed to multifamily units being built in close proximity to their homes. The people became so busy fighting a proposed through street from a busy complex connecting with a street through their division, they forgot to fight the rezoning and the apartment and the street were both built. They were double losers.

We are going to have changes in our health care system. We have had them since 1965-1967 when Medicare and Medicaid were enacted. We are still fighting those regulations and the regulations like MAC that were created to carry out the aforementioned laws.

Health care professionals are the providers of care. We should find out what care our patients want and develop the model or models to meet their needs. With the economy the way it is, each hospital cannot have total body scanners, do heart transplants and the like. We must unite and do away with our old ideas and all of our infighting.

What's wrong with hospitals coming together in a community and through

discussion and planning decide that hospital A will handle maternity, hospital B heart transplants, hospital C bodyscans, etc? What's wrong with hospitals having open staffs? That is, all physicians in a community being allowed admitting privileges in each hospital? For such a system to work there would probably have to be a community medical credentials committee, instead of each hospital having one.

There also might be the need for a centralized community hospital admitting center. The center would assign patients to the hospital that provided the care, service, or diagnostic service that was required. It would also be able, for general surgery and Medicare beds, to keep patients more evenly dispersed. Maybe even close hospitals, if patient census makes it necessary.

Some of this perhaps sounds like government programs that we had in the past, regional medical centers, specialization of hospitals and services, etc. However, the difference is that it would be organized and planned by the health care leaders in the community and not mandated by some government regulation. We all blame the government for too much regulation and red tape, but we do very little to make our system more efficient and economical for the patients we serve.—"Action in Pharmacy" newsletter, Kansas City, Mo.

#### Alcoholism, Drug Counselors to Meet

Many of the nation's best known experts in the alcohol/drug abuse field will gather at Indianapolis' Adams Mark Hotel, Aug. 5-8, for the 1984 conference of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC).

Speakers and presenters will include: Janet Woititz, Ed.D., author of Adult Children of Alcoholics and Marriage on the Rocks;

Sen. Harold Hughes, father of legislation to establish a government institute with federal funding for national programs for alcoholism; Mary Pendery, Ph.D., psychologist, clinical researcher and assistant clinical professor, Dept. of Psychiatry, University of California School of Medicine, most recently known for her exposition of findings of a "controlled drinking" study;

David York, creator of "Tough Love" for parents;

Dan Anderson, president of the Hazelden Foundation and a pioneer in alcoholism treatment;

Robert F. Stuckey, M.D., consultant for American Healthcorp in development of alcoholism service, and medical director of Fair Oaks in New Jersey;

Terence Gorski, president of Alcoholism Systems Associates and consultant to alcoholism programs; and

Janet Guthrie, the only woman to race in the Indy 500 and a staunch supporter of drunk driving legislation.

The conference theme is "Where We've Been, Where We're Going." It is being hosted by the Indiana Counselors Association on Alcohol and Drug Abuse.

For the complete program and registration forms contact ICAADA, 1800 N. Meridian, Suite 507, Indianapolis 46225—(317) 923-8800.

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#### AUXILIARY REPORT

Judy Koontz (Mrs. James A.) President, ISMA Auxiliary

ISMA auxilians honored their outgoing president, Hulda Classen of Elkhart, and Judy Koontz of Vincennes assumed the presidency during this year's meeting of the Auxiliary House of Delegates, conducted April 25-26 at the Midway Motor Lodge in Elkhart.

Mrs. Classen, whose presidential theme was "Building for the Future," reported that Auxiliary membership increased by 50 to 2,591 during her tenure. She and former Auxiliary presidents were honored at a dinner April 24 at the Christiana Creek Country Club.

"Make Somebody Happy—By Caring and Sharing" is the new theme chosen by Mrs. Koontz. She challenged auxilians to help raise funds for community health care facilities, scholarships through AMA-ERF, and other health-related programs. She also urged members to keep abreast of legislation, particularly proposals dealing with the cost of health care and the control of patient care.

The president-elect of the AMA Auxiliary, Billie (Mrs. Wayne C.) Brady, delivered the keynote address to the House of Delegates. She declared that the Auxiliary must remain "viable and strong, but flexible." She encouraged

diversity and membership growth "if we are to stay up-to-date." She said one way to help overcome any negative image that medicine may have is for auxilians to work as volunteers in various community health-related programs. She cited programs such as child abuse, blood

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donor drives, and legislative efforts to reduce drunk driving and to increase the use of automobile safety belts as ways of showing communities that "medicine cares." Among reports of last year's activities was an announcement that nearly \$66,500, representing Auxiliary and ISMA contributions for AMA-ERF, was presented last fall to the Indiana University School of Medicine. Of this amount, the largest AMA-ERF allocation given to a single medical school in the United States, the Auxiliary donated more than \$39,500. (Allen County contributed the largest total dollar amount, more than \$5,500, and Jay County, with nine members, contributed the largest per capita amount, nearly \$70 per member.) This year's goal has been set at \$45,000.

ISMA representatives presented briefings on matters of concern at the state level. Donald Foy, ISMA executive director, explained some of the problems regarding the increase in malpractice insurance costs, and encouraged auxilians to establish rapport with senior citizens, particularly by helping them file Medicare claims. Howard Grindstaff, field services, presented an AMPAC-IMPAC update, pointing out that of the 409 candidates supported by AMPAC in the last election, 84% were elected.

The Auxiliary House of Delegates will meet next April in Vincennes.

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#### BOOK REVIEWS

#### The Social Transformation of American Medicine

By Paul Starr, Sociology instructor, Harvard University. Copyright 1982, Basic Books, Inc., New York. \$19.95.

This 449-page text with an additional 46 pages of Reference Notes was started by its author in 1974 with a three-year fellowship at Yale University, which was then followed by one at Harvard University. The former was on the subject of Law, Science and Medicine which was subsidized by the Commonwealth Fund. The John Simon Guggenheim Memorial Foundation supported him while he was a visitor at Yale's Institution for Social and Policy Studies from 1981 to 1982, where the book was completed.

A close scrutiny of the Reference Notes indicates a preponderance of individuals and publications that are known for their socialist persuasion. For example, Professor George S. Counts of Columbia University was one of the first individuals to recommend, in 1950, that the best way for us to fight Communism was to adopt Socialism. Then there are many references to Arthur J. Altmeyer's works, and those of Isadore S. Falk who had been officials in our Social Security Administration for many years. I am personally familiar with the liberal activities of 32 other names on that extensive reference list, and could find the names of no well known conservative authors, publications or organizations on any of those 46 pages. I will mention but a few of these who could have presented wholesome ideas to the author: Ludwig von Mises, Melchior Palyi, Leonard Read, Howard Kershnes, George S. Benson, and R. J. Rushdooney. Such exponents of free enterprise, individual responsibility and constitutional government would have to be eliminated from a treatise that was intended to give readers the false idea that most of the medical profession had been transformed to an abject acceptance of socialism by the Twentieth Century.

His introduction to the following voluminous 11 chapters of this text deals with the social origins of professional sovereignty, and says that the dream was that reason, in the form of the arts and

the sciences, would liberate humanity from scarcity and the caprices of nature, ignorance, superstition, tyranny and disease.

He then postulates that the history of medicine, while showing much progress in that field of endeavor, has also involved the development of social and economic conflict, authority and power which he thinks it should not have. Throughout the rest of the book he frequently alludes to that power and authority sought by physicians as though that were their main purpose in life instead of it being the healing of the ill.

He portrays the 18th and 19th Century doctors as underpaid and almost destitute until the 20th Century when they became powerful and wealthy far beyond their needs. That idea smacks of Karl Marx who was not listed in his references.

He tells us about doctors incorporating in the current century, the new standards for hospitals and their medical staffs, the subtle intrusion of government into the practice of medicine, and the excessive costs of medical care by doctors and hospitals today, as though only the medical profession and its affiliates were the cause of a monetary inflation caused solely by unconstitutional government activities. So, the author feels that the cure for the high costs of medical care was to put price controls into effect instead of telling us the need to put the chains of the Constitution on our illegal government activities.

Starr failed to tell his readers about well known organizations of doctors that have been fighting these unauthorized activities of our federal government. The first one, born in Indiana nearly half a century ago, is the Association of American Physicians and Surgeons (AAPS). It has been re-educating doctors, patients and the public to the need for a return to free enterprise, personal responsibility and constitutional government. They have since been joined by the Council of County Medical Societies (CCMS) and Private Doctors of America (PDA) for similar purposes.

I know of no such organization that Starr mentions as the American Association of Physicians which he said was a right wing branch of the American Medical Association that sued the government over the constitutionality of the PSROs. Earlier in his text, Starr refers to an American Association of Physicians formed in 1880 as a strictly scientific organization of doctors who did not like some of the political activities of the AMA. I must assume that the eastern universities, that provided Starr with source material for his book, did not include the existence of the AAPS, CCMS, and the PDA.

Did the references available to Starr also exclude the books by Anthony Sutton that exposed the true source of the organizations that had secretly been using their power to push this Republic into a One World Tyranny of Socialism? Those organizations have been exposed by other authors for many years, but when books came out by a knowledgeable associate of the Council of Foreign Relations and the Trilateral Commission, it got more extensive recognition, except by the eastern establishment. The Council of Foreign Relations and the Trilateral Commission are the power mongers that have created our current sad financial plight-not the medical profession. There may be a few doctors, like Armond Hammer in those organizations who have been aiding the communists, but their evil intent cannot be placed upon the bulk of physicians whose primary interest is to repair the diseases and injuries of their patients.

Starr's book must be considered as another means to advance the false ideology of socialism for the ultimate demise of our freedom protecting Constitution of the U.S.A.

A. G. Blazey, M.D. Santa Claus, Ind. General Practice

Andent Press announces Computers for Professional Practice. The author is E. J. Neiburger. The book is written to acquaint physicians and other professionals with the functions of computers, how to decide whether a particular practice would gain with computerization, when to computerize and how to do it without getting stung. The author discusses hardware, software, applications and potential problems. 281 pages, \$14.95.

#### Current Emergency Diagnosis & Treatment

Edited by John Mills, M.D., Mary Ho, M.D., and Donald D. Trunkey, M.D. Copyright 1983, Lange Medical Publications, Los Altos, Calif. 738 pages, softcover, \$24.

As interest in Emergency Medicine has increased there has been a parallel increase in the number of texts attempting to cover this vast field. Because the field is too diverse for one text, most of these efforts have failed from the start. By indicating from the start that the goal of this text is to briefly outline emergency diagnosis and treatment, however, the editors have at least set a reasonable goal for themselves.

The text is organized by chapters each dealing with a specific presenting complaint or symptom, such as chest pain, coma, abdominal pain, dyspnea, etc. Organizing information in this way, rather than by diagnosis, makes it quite easy to use the book to refine a differential diagnosis. Although the chapters have different authors, they follow the same format. A diagnostic algorithm is presented first, walking the reader through a logical sequence of diagnostic tests and procedures to refine a differential diagnosis. Each diagnosis considered is then discussed in terms of definitive findings, treatment and disposition. This organization is actually quite useful.

In addition to the sections on therapy, "Emergency Care and the Law," "Administration," "Mass Casualties" and

"Emergency Procedures" are also addressed in separate chapters. This material is especially appropriate to Emergency Medicine and serves as a succinct introduction to these areas of the specialty.

The text does accomplish its intended purpose of providing an outline of the various aspects of Emergency Medicine and emergency care. I feel that it would be excellent reading material for students and first-year residents rotating in the Emergency Department. The chapters on weakness, coma, and abdominal trauma are especially good for this purpose. However, most of the chapters are too brief and superficial for advanced students of Emergency Medicine, and those on resuscitation and poisoning are too brief to be of much use to anyone.

Recognizing the limitations of a brief and superficial overview, I feel that the authors have provided a valuable text useful for orienting students and junior residents to emergency care.

Terry Crafton, M.D.
Indianapolis
Emergency Medicine

Running Press has published *The Diabetics Brand-Name Food Exchange Handbook*. It is a comprehensive, reliable, brand-name reference book with complete information on food exchanges. Cloth-bound, 288 pages, \$14.95.

Preferred Provider Organizations is a book to be published in the latter part of 1984 by Dow Jones-Irwin Publishing Company. Inpatient cost control is the main subject of discussion. The authors are Frederick Fink and Richard Wesslund of Booz, Allen & Hamilton's Health and Medical Division. Included are (1) an array of advice to those involved with PPO's, (2) other advice to payors of medical care expenses, and (3) an analysis of hospital management, by front office and medical staff, and nursing staffs in the effort to keep medical costs within the DRG payments.

Thieme-Stratton announces *Pyelonephritis* by H. Losse, M.D., A. W. Asscher, M.D., and V. J. Andriole, M.D. This volume is the result of the Fourth International Symposium on Pyelonephritis held in Munster, Germany. It presents pathophysiology, diagnosis, epidemiology and modern treatment. It is directed to nephrologists, urologists and infectious disease specialists. 179 pages, 92 figures, 83 tables, soft cover, \$30.

Thieme-Stratton announces Antineoplastic Chemotherapy, written by Helmut Kuemmerle, M.D. of Tokyo Medical College. The text is addressed to all physicians who work with clinical chemotherapy in both practice and research. International authorities have contributed as representatives of various disciplines. 587 pages, \$75.

#### PUBLIC HEALTH NOTES. . .

CONTINUED FROM PAGE 513

—also new to the state's rules is the requirement that a pharmaceutical services committee be formed to meet quarterly and provide documentation of its activities, findings and recommendations to the facility administrator. This committee is to be made up of the pharmacist, the director of nursing services, the administrator and the medical director; and

—a great deal of common sense and good judgment is called for in the requirement that nursing personnel in charge shall be responsible for notifying the resident's physician when, in their professional judgment, there has been an incident of sufficient magnitude to inform the physician. All attempts to notify the physician shall be documented in the resident's record including the time and method of communication, the name and title of the person making the

contact and the name of the person acknowledging the contact.

These rules are longer and more specific than those under which we have operated previously. While it is true that they provide a minimum guideline for the performance of Indiana health facilities, the rules will reform very little without the continued interest and concern of the nursing home industry, consumers, families, advocates and health care professionals.

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#### CME QUIZ.

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: Indiana University School of Medicine, CME Division, Fesler Hall 224, 1120 South Dr., Indianapolis 46223.

#### **Short Stature**

**CONTINUED FROM PAGES 515-519** 

- 1. Determination of bone age may indicate the following:
  - a. Level of physical maturation
  - b. Growth potential
  - c. A factor in predicting adult height
  - d. All of the above.
- 2. Bone age may be within normal limits in all of the following except:
  - a. Familial short stature
  - b. Prolonged hypothyroidism
  - c. Gonadal dysgenesis
  - d. Intrauterine growth failure
- 3. A definitive diagnosis of growth hormone deficiency is made by:
  - a. Height greater than four standard deviations below the mean.
  - b. Low serum level of somatomedin C.
  - Failure of response to two standardized provocative tests for growth hormone release.
  - d. Bone age delayed by more than three years.
- 4. Anterior pituitary hormones used in the treatment of panhypopituitarism are:
  - a. ACTH and growth hormone

- b. Growth hormone only
- c. TSH, ACTH, growth hormone
- d. LH, FSH and growth hormone
- 5. The replacement dose of thyroxine per unit of body size in children:
  - a. Increases with increasing age
  - b. Remains the same with increasing age
  - c. Decreases with increasing age
  - d. Varies erratically from patient to patient with increasing age.
- Benefits of treatment with sex steroids in a fifteen year old male with constitutional delayed growth and adolescence include all of the following except:
  - a. Fairly prompt noticeable increase in growth rate.
  - b. Increased final adult height
  - c. Fairly prompt, noticeable advancement in secondary sexual develop-
  - d. Aids in maturation of hypothalamicpituitary-gonadal axis.
- A typical growth curve in a patient with constitutional delayed growth and physical maturation is characterized by

- all of the following features except:
- a. "Catch-up" growth in mid child-hood.
- b. Normal size at birth
- c. Normal growth rate in mid childhood
- d. Height which is equivalent to about the fiftieth percentile for children of the same sex who are two to four years younger.
- 8. Complications of treatment with anabolic steroids include all of the following except:
  - a. Advance of bone age to a greater degree than advance in height age.
  - b. Altered liver function
  - c. Excessive nitrogen retention
  - d. Acne and undesirable hair growth
- 9. Which one of the following diagnoses may be characterized by functional (or transient) hypopituitarism?
  - a. Gonadal dysgenesis
  - b. Intrauterine growth retardation (IUGR)
  - c. Psychosocial dwarfism
  - d. Constitutional delayed growth and adolescence
- The most valuable data in the investigation of a patient with short stature is provided by:
  - a. Evaluation of bone age
  - b. Determination of serum somatomedin
  - c. Determination of parental heights
  - d. Evaluation of a growth chart for the

#### JUNE CME QUIZ Answers

Following are the answers to the CME quiz that appeared in the June 1984 issue: "An Update on the Hyperlipidemias and Atherosclerosis," by Richard C. Powell, M.D.

- 1. c 6. a 7. d 3. b 8. b 4. d 9. b 5. b 10. a
- Answer sheet for Quiz: (Short Stature)

 1. a b c d
 6. a b c d

 2. a b c d
 7. a b c d

 3. a b c d
 8. a b c d

 4. a b c d
 9. a b c d

 5. a b c d
 10. a b c d

I wish to apply for one hour of category I AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of Indiana Medicine for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for this month's quiz, send your completed, signed application before Aug. 10, 1984 to the address appearing at the top of this page.

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#### DEWS DOTES

#### **Polaroid Photo Contest**

Polaroid is conducting its third annual contest for microscopists who use instant photography to record images. Three travel prizes worth up to \$2,000 are offered in addition to prizes of Polaroid 35mm instant slide systems, instant photomicrography systems, instant slide printers and Polaroid cameras.

Entries for the 1984 contest must be postmarked no later than Oct. 5 and must be accompanied by an official entry form. Rules and entry forms may be obtained from: Polaroid Photomicrography Competition, 575-9P Technology Sq., Cambridge, Mass. 02139.

#### Holter Analyzer

The application of a standard ventricular arrhythmia tape database for determining the accuracy of a commercial, high-speed Holter analyzer is described in a new six-page brochure from Del Mar Avionics.

The study, conducted on a Del Mar Avionics Trendsetter® II Holter Scanner, using the Model 9021 Arrhythmia Analyzer, employed the standard Holter tape database developed by the American Heart Association.

The database consisted of Holter tapes derived from 60 different patients, each tape containing 30 minutes of electrocardiographic data annotated with nor-



mal, ventricular, escape, paced, questionable and unreadable labels.

Contents of the accuracy report include methods, results, discussions and correlating tables. Additionally, all raw data for each tape segment is presented. Thus, users can directly compare the database hand count with the machine count

This is the first public report from any Holter manufacturer that utilizes the American Heart Association standard database.

The report and related literature are available upon request from Del Mar Avionics, 1601 Alton Avenue, Irvine, Calif. 92714.

#### **Anorexia Factsheet**

"CNS Factsheet: Anorexia Nervosa and Bulimia—Dangerous Forms of Weight Control" is the title of a short dissertation issued by the Neurosciences Information Center, a professional service of The Upjohn Company.

The factsheet explains the main features of each disorder, the associated personality and family background and methods of treatment. By permission of Upjohn, single copies of the dissertation may be obtained from INDIANA MEDICINE on written request.

#### **DRG Penalty Statement**

The DRG penalty statement that physicians are required to sign under Medicare's new prospective payment system is not meant to imply that they will be held responsible for the medical record department's coding of a case.

In a letter to the AMA, the U.S. Dept. of Health and Human Services said that, despite the wording of the DRG validation statement, physicians are not expected to know the 1CD-9-CM coding system or how to assign diagnosis-related groups.

"Basically, the requirement for physician attestation simply extends to Medicare the long-established practice of requiring the physician to sign the face sheet of the medical record," an HHS official explained. HHS is preparing a

new draft regulation to clarify that the physician is only attesting to primary and secondary diagnoses and major procedures, and is not responsible for the coding.

#### Limited Health Risks After Dioxin Exposure

Accidental workplace exposure to herbicide contaminants, including dioxin, does not result in increased risk for cardiovascular diseases, liver disease, kidney damage or central nervous system problems.

An accident occurred on March 8, 1949 in a plant in Nitro, West Virginia. The health experience of 204 exposed employees was studied and compared with a control group of 163 present or former employees not exposed to the accident. The cleanup crew and those who repaired the damaged machinery had acute symptoms immediately, which cleared in two weeks. Other symptoms followed including chloracne.

By 1953 symptoms such as muscle pain, nervousness, and liver enlargement and peripheral neuritis had subsided. Chloracne continued. No excess of cancer incidence or cirrhosis could be demonstrated. The same observation was made for reproductive problems and birth defects.



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#### NEWS NOTES

#### For the Asking . . .

- An AMA report called "Guide to the Hospital Management of Injuries Arising from Exposure to or Involving Ionizing Radiation" is available for \$6, plus \$3.50 for shipping and handling. Order Dept.—OP35, American Medical Association, P.O. Box 10946, Chicago 60610.
- General Electric has published an eight-page brochure describing and illustrating the use of GE's C-arm Polarix<sup>TM</sup> 2E surgical mobile image intensifier. Clinical images are produced through thick lumbar regions. The fluoroscopic system is planned for use in surgical suites for such applications as intramedullary fixation of the femur, hip pinning, cardiac pacemaker implants and operative cholangiography. No charge. For a copy of Brochure #5512, write to GE, P.O. Box 414, W-412, Milwaukee, Wisc. 53201.
- The National Kidney Foundation has published a brochure entitled "Nutritional Considerations for the Patient before the Initiation of Dialysis." Available through local affiliates or from the National Kidney Foundation, 2 Park Ave., New York, N.Y. 10016.
- "Pesticides in Your Home and Garden" is the subject of a 24-page pamphlet published by the American Council on Science and Health. Advice on how to deal with warm weather pests and

- safety precautions are stressed. For a complimentary copy, send a stamped (37 cents), self-addressed, business size envelope to Pesticide Report, ACSH, 47 Maple St., Summit, N.J. 07901. Additional copies may be purchased with a discount for large quantities.
- "101 Basic Ideas to Improve Your Practice" is a book designed to aid in building a medical practice and in maintaining it with success. The author, widow of a highly successful physician, has distilled all the rules for managing the office, for establishing and caring for good public relations and for hospital staff relationships that are so important today with the rapidly increasing supply of physicians. The book is the subject of a very favorable review in *Private Practice*. \$6.50. Contact Iris L. Spira, 3616 Dover Drive, Birmingham, Ala. 35223.
- Radiation injuries are discussed in the AMA publication, "Guide to the Hospital Management of Injuries Arising from Exposure to or Involving Ionizing Radiation." \$6 plus \$3.50 for shipping and handling. AMA Order Dept. OP 35, P.O. Box 10946, Chicago 60610.
- "Alcohol & Pregnancy: Why They Don't Mix" is the title of an AMA booklet that points out a fetus in utero has the same alcohol concentration in its circulation as does its mother. Fetal Alcohol Syndrome (FAS) is a group of diagnosable birth defects that can occur

- when a pregnant woman drinks alcohol heavily for a prolonged time; best advice is not to touch alcohol while pregnant. Single copy available free of charge from Health Education, AMA, P.O. Box 10947, Chicago 60610. For multiple copies, write Order Dept., AMA, 535 N. Dearborn, Chicago 60610.
- "Making It Better: How Everyone Can Create a Safer Workplace" is a 10-minute film, plus workbook, produced by Allied Corporation that shows how workers get safety ideas based on things they see in their work areas and get these ideas turned into safety improvements. 16mm, 3/4-inch videocassette, Betamax or VHS. For details, contact Customer Service, BNA Communications, Inc., 9439 Key West Ave., Rockville, Md. 20850.

#### **Hospital Dedication**

The new 120-bed Culver Union Hospital in Crawfordsville was dedicated on June 9. Governor Robert Orr was the dedication speaker. The new hospital was built by American Medical International (AMI) after the county-owned original Culver Union Hospital was purchased from the county by AMI. AMI is an international health services company, providing services to more than 500 communities on six continents.

#### - Physician Recognition Awards -



The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.



Aldred, Allen W., Fort Wayne Bennett, Benjamin D., Kokomo Cooperman, Alan S., Fort Wayne Esquerre, Francis A., Bedford Faw, Melvin L., Evansville Ferguson, James F., Bloomington Gabrys, G. Thomas, Fort Wayne Griffin, Charles G., Valparaiso Henderson, Lawrence W., Indianapolis Hichman, Donald M., Fort Wayne Huguenard, Joseph R., Fort Wayne Inlow, Paul M., Shelbyville Losch, Christian J., Elkhart Marty, Alan T., Evansville Norins, Arhtur L., Indianapolis Rietman, H. Jerome, Evansville Shoemaker, Robert E., Indianapolis Simmons, James E., Indianapolis Smith, Donald W., South Bend Vaughn, Walter R., Vincennes

#### **New ISMA Members**

The following physicians were welcomed in April as new members of the Indiana State Medical Association:

Kondreddy K. Chowdary, M.D., Highland, obstetrics and gynecology

Donald G. Cvitkovich, M.D., Hobart, pulmonary diseases

Walter W. Eckman, M.D., Columbus, neurological surgery

Salah A. Elsaharty, M.D., Anderson, urological surgery

Arvindkumar N. Gandhi, M.D., Munster, cardiovascular diseases

Hubert Honer, M.D., Jeffersonville, general surgery

Robert W. Hongen, M.D., Bloomington, family practice



Joseph B. Koscielniak Jr., M.D., Merrillville, orthopedic surgery

Marsha L. Muldrow, M.D., Gary, dermatology

Thomas M. O'Connor, M.D., Greenfield, family practice

Benjamin S. Plotkin, M.D., South Bend, anesthesiology

Henry S. Shin, M.D., East Chicago, therapeutic radiology

Patrick C. Silveus, M.D., Indianapolis, family practice

George D. Taylor, M.D., Huntingburg, obstetrics and gynecology

Hemangini M. Trivedi, M.D., Fort Wayne, pediatrics

Daniel J. Wenzl, M.D., Madison, ophthalmology

#### Here and There . . .

- ... **Dr. J. Vannoy Faris**, an Indianapolis cardiologist, has been named chief of staff of the VA Medical Center, Indianapolis.
- ... **Dr. David G. Pietz** of Bluffton participated in two April public education programs on colorectal cancer at the Caylor-Nickel Medical Center.
- . . . Dr. Charles O. McCormick, III, a Franklin ophthalmologist, appeared in May on "Focus," a WTTV community affairs program, to discuss glaucoma and the prevention of blindness.
- ... **Dr. Ervin W. Heiser** of Elkhart was guest speaker at the May meeting of the Elkhart-South Bend Area HELP Group, a genital herpes support group.
- . . . Dr. David E. Ross of Gary was guest speaker at the May meeting of the Alzheimer's Disease Support Group of Gary.
- Bend discussed "Diet for a Healthy Heart" during a public lecture series in South Bend in May.
- ... **Dr. Michael E. Lapp** of Indianapolis discussed "How Not to Have a Heart Attack" in May at Morgan County Memorial Hospital.
- ... Dr. Garciela Hernandez-Flores, an East Chicago psychiatrist, has been named medical director of Tri-City Community Mental Health Center.
- ... Dr. George T. Lukemeyer of Indianapolis, ISMA president, has been chosen as secretary general of the American College of Physicians.

- ... **Dr. Michael A. Borkowski**, a South Bend rheumatologist, participated in a panel discussion on "Enjoying Life Despite Chronic Illness" during a May forum sponsored by the Arthritis Society of St. Joseph County.
- Danville, Herschell Servies Jr. of Lebanon and Mary H. Knotts of Lebanon participated in a three-program series on diabetes in May sponsored by Witham Memorial Hospital.
- Bend neurologist, was among guest speakers at a May seminar sponsored by the Northern Indiana Chapter, National Multiple Sclerosis Society.
- ... **Dr. John E. Ramsey** of Kendallville has been elected to the board of directors, Association of American Physicians and Surgeons.
- ... **Dr. Richard C. Powell** of Indianapolis has become Indiana governor of the American College of Physicians.
- ... Drs. Jeffrey C. Darnell of Carmel, James M. Fattu of Evansville, Redmond P. Hogan III of Indianapolis and Robert W. Clausen of South Bend have been inducted as fellows of the American College of Physicians.
- ... **Dr. Robert A. McDougal**, a Danville pathologist, has been elected president-elect of the Indiana State Association of Blood Banks.
- ... **Dr. Lowell H. Steen** of Hammond discussed the evaluation and management of hypertension during a May seminar sponsored by the East

- Chicago Dept. of Health's Hypertension Education and Monitoring Program.
- ... **Dr. Devendra Desai** of Plymouth has been named a diplomate of the American Board of Surgery.
- ... **Dr. Austin L. Gardner** of Indianapolis presented a paper entitled "Fiberoptic Applications of the Laser in Vascular Surgery" at the May meeting of the Indiana Chapter, American College of Surgeons.
- ... Dr. George T. Lukemeyer of Indianapolis, ISMA president, has been presented the 1984 Vital Award by the Marion County Chapter, American Heart Association.
- ... Drs. Eugene W. Austin, Patrick J.V. Corcoran, Edgar L. Engel, Joseph C. Lawrence and J.D. McDonald, all Evansville physicians, were presented Community Service Awards in May by the Vanderburgh County Medical Society.
- dianapolis presented an article entitled "Patency in Canine Inferior Vena Cava Grafting" at last month's meeting of The Society for Vascular Surgery. His collaborators were Dr. Austin Gardner, Pamela Peigh, David Madison, John Brown, John Glover and Sally Baughman.
- dianapolis has been elected president of the Neurosurgical Society of Indiana; Dr. Marvin R. Bernard of Merrillville is vicepresident, and Dr. Michael R. Burt of Indianapolis is secretary-treasurer.

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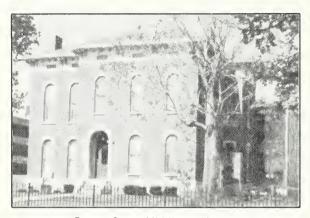
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# OBITUARIES.

### Lester D. Bibler, M.D.

Dr. Bibler, 82, a retired Indianapolis physician in whose name the Indiana University School of Medicine established an endowed professorship in family medicine in 1979, died May 29 at his home.

He was a 1925 graduate of Indiana University School of Medicine who, in 1978, received the Maynard K. Hine Mcdal, given to I.U. alumni for outstanding contributions to their professions, community and alma mater. He had been an associate professor at the school.

Dr. Bibler, who retired in 1980, was a Navy veteran of World War II. He was a former ISMA trustee, a former member of the AMA Board of Trustees, and first president of the Indiana Academy of Family Practice. He was a member of the ISMA Fifty Year Club, the American Academy of Family Physicians, the American Geriatrics Society, and the Association of Military Surgeons of the United States.

### Andrew E. Russo, M.D.

Dr. Russo, 52, a Crown Point physician until last year, died May 25 at St. Anthony Medical Center.

He was a 1956 graduate of Indiana University School of Medicine.

Dr. Russo had practiced in Crown Point 27 years. He was a former associate with the Crown Point Clinic.



Dr. Bibler

### Thomas F. Teller, M.D.

Dr. Teller, 49, an Evansville clinical pathologist who was a candidate for Vanderburgh County coroner, died May I at St. Mary's Medical Center.

He was a 1962 graduate of the University of Cincinnati College of Medicine. He served in the Air Force from 1963 to 1966.

Dr. Teller, who once played professional football for the San Diego Chargers, was certified by the American Board of Pathology and was a fellow of the College of American Pathologists.

### Stanley M. Hammond, M.D.

Dr. Hammond, 69, a Munster psychiatrist, died April 24 at LaPorte Hospital.

He was a 1939 graduate of Indiana University School of Medicine and was a Navy veteran of World War II.

Dr. Hammond, who formerly practiced in Portland, Ind., was a past president of the Jay County Medical Society. He was a member of the American Psychiatric Association.

### Eli B. Harter, M.D.

Dr. Harter, 75, former head of the radiology department at the Arnett Clinic, Lafayette, died May 15 at Home Hospital.

He was a 1937 graduate of Indiana University School of Medicine and was a flight surgeon with the Army-Air Corps during World War II.

Dr. Harter, who retired in 1974, was certified by the American Board of Radiology and was a fellow of the American College of Radiology.

### Melville E. CaJacob, M.D.

Dr. CaJacob, 79, a retired Terre Haute physician, died May 12 at St. Vincent Hospital, Indianapolis.

He was a 1939 graduate of the University of Cincinnati School of Medicine and was an Army veteran of World War II.

Dr. CaJacob, who practiced in Terre Haute 35 years, retired in 1981. He was a past president of the Vigo County Medical Society.

### te

Dr. Cahn, 87, a retired Indianapolis physician, died May 13 at St. Vincent Hospital.

Hugo M. Cahn, M.D.

He was a 1939 graduate of Indiana University School of Medicine, but previously earned the M.D. degree in 1922 from the University of Wuerzburg.

Dr. Cahn, a native of Witten, Germany, retired in 1967. He was a member of the ISMA Fifty Year Club and the American Academy of Family Practice.

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### Leonard W. Neal, M.D.

Dr. Neal, 63, a Munster physician who was a former ISMA alternate trustee and delegate, as well as a former president of the Lake County Medical Society, died May 20.

He was a Navy veteran and was a 1947 graduate of the University of Tennessee Center for the Health Sciences, Memphis.

Dr. Neal, who helped found the Hammond Clinic in Munster, was a member of the American Academy of Family Physicians.

### Horace D. Bell, M.D.

Dr. Bell, 67, a South Bend physician, died April 13 at his home.

He was a 1952 graduate of Indiana University School of Medicine and was an Army veteran of World War II.

Dr. Bell practiced in South Bend 21 years.

### James S. Browning, M.D.

Dr. Browning, 75, an Indianapolis internist, died May 5 at the University of Cincinnati Hospital.

He was a 1935 graduate of Indiana University School of Medicine and was an Army veteran of World War II.

Dr. Browning practiced in Indianapolis 48 years.

### Francis B. Mountain, M.D.

Dr. Mountain, 78, a retired Connersville surgeon, died May 16 at his home in Port Saint Lucie, Fla., where he had lived since retiring in 1978.

He was a 1931 graduate of the University of Michigan Medical School.

Dr. Mountain, a member of the ISMA Fifty Year Club, had a private practice and was on the staff at Fayette Memorial Hospital 42 years. He was a former president of the Fayette-Franklin County Medical Society.

### Jefferson I. Streepey, M.D.

Dr. Streepey, 65, a New Albany physician, died May 19 at Jewish Hospital, Louisville.

He was a 1943 graduate of the University of Louisville School of Medicine, and a veteran of World War II.

Dr. Streepey was medical director of Green Valley Convalescent Center and was a past president of the Floyd County Practicing Physicians. He was a member of the American Academy of Family Physicians.

### George R. Donahue, M.D.

Dr. Donahue, 83, a retired Lafayette physician and surgeon, died April 20 at St. Elizabeth Hospital, Lafayette.

He was a 1925 graduate of the St. Louis University School of Medicine and was an Army veteran of World War II.

Dr. Donahue, who retired in 1976, was a member of the ISMA Fifty Year Club.

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Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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References: 1. Kales J et al: Clin Pharmacol Ther 12:691-697, Jul-Aug 1971. 2. Kales A et al: Clin Pharmacol Ther 18:356-363, Sep 1975. 3. Kales A et al: Clin Pharmacol Ther 19:576-583, May 1976. 4. Kales A et al: Clin Pharmacol Ther 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR. J Am Geriatr Soc 27:541-546, Dec 1979. 6. Kales A, Kales JD: J Clin Pharmacol 3:140-150, Apr 1983. 7. Greenblatt DJ, Allen MD, Shader RI: Clin Pharmacol Ther 21:355-361, Mar 1977. 8. Zimmerman AM. Curr Ther Res 13:18-22, Jan 1971. 9. Amrein R et al: Drugs Exp Clin Res 9(1):85-99, 1983. 10. Monti JM. Methods Frind Exp Clin Pharmacol 3:303-326, May 1981. 11. Greenblatt DJ et al: Sleep 5(Suppl 1): S18-S27, 1982. 12. Kales A et al: Pharmacology 26:121-137, 1983.

DALMANE® ® flurazepam HCI/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCI, pregnancy. Benzodiazepines may cause tetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, fry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined. **Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



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DOCUMENTED IN THE SLEEP LABORATORY 1-5

**PROVEN IN** THE PATIENT'S HOME



FOR A COMPLETE NIGHT'S SLEEP

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AUGUST 1984 VOL. 77

**NO.8** 

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### ABOUT THE COVER



The legendary, dying "May Tree" near the entrance of Coleman Hall survived until renovation and re-landscaping began. For more about what began as the William H. Coleman Hospital for Women in Indianapolis, turn to page 622.

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## MEDICAL MUSEUM NOTES

CHARLES A. BONSETT, M.D., Indianapolis



RUDDER IS A DEVICE whose function is to control the direction of the entity to which it is attached. Some physicians are like rudders in that they perceive more clearly than most the direction that some aspect of medicine should take; and they then use their influence to move the profession to the correct course. Dr. Alembert W. Brayton was such a man.

An example of his activity in this regard is to be found at the 1888 meeting of the Indiana State Medical Society where the values of certain recent advances in medicine were being discussed. Of particular concern was the alleged value of antiseptic techniques and the use of forceps in the practice of obstetrics. Older physicians in particular were skeptical of change.

Dr. "A", a physician of the old school, prefaced his talk with the opinion that the quality of current care in his county was excellent and that to make any kind of a change was not only not warranted, but would present a risk. He then proceeded to give statistics "gathered from case books of a few of the older practitioners of (his) county, embracing 3,752 cases of confinement."

The first example given was the experience of Dr. "B" who had attended 1,600 cases of labor over a 29-year period. Obstetrical forceps were used 20 times. The doctor never lost a case in labor, but one in childbed fever, none from postpartum hemorrhage, and one from puerperal convulsions. The only approach to antiseptic treatment was the occasional use of a vaginal wash of potassium permanganate.

Dr. "C" had 525 confinements in 18 years, had never used obstetrical forceps, and had never used any type of antiseptic precautions. He had lost only one case from a ruptured uterus, none from postpartum hemorrhage, one from puerperal convulsion and three from childbed fever.

Dr. "D", whose only antiseptic precaution consisted of dipping his hands in carbolized water prior to his examinations, had attended 708 labors in 20 years, and



Dr. Brayton

had need for forceps on three occasions only. He had lost two women in labor, one from placenta praevia, one from puerperal apoplexy, and none from childbed fever.

The experiences of Dr. "E" (20 years, 500 cases) and of Dr. "F" (419 cases in 12 years) were equally impressive, since neither had recourse to obstetrical forceps or use of antiseptic precautions, and had only minimal fatality.

In all, there were 3,752 cases with a total of 12 deaths. Forceps were used only 31 times and antiseptic measures were minimal or absent.

Dr. "A" concluded his remarks by stating, "Could the skilled use of instruments with the most approved antiseptic treatment have made a better record? In all events we challenge comparison!"

Comparison was not immediately forthcoming. Rather, other physicians, all from the older school, who had warmed to the speaker's thesis, arose to cite their own statistics, which were in agreement with the concept that antiseptic procedure was a passing fad and that the value of instruments was considerably overrated.

Dr. Brayton was then given his oppor-

tunity to speak:

"Mr. President," he said, "I think it's time we called a halt. I may not be competent to do it myself, but I think there have been reported and things said here that should be accepted with caution. We must make great allowance for these venerable gentlemen whom we honor and who have taught us so much. Puerperal fever does occur. It occurs here. You don't find it on the records of our Board of Health for the very good reason that physicians don't report it. It is not to their credit. I believe that these statistics are radically wrong. I hope other gentlemen, who have had extensive practice in obstetrics, who have had deaths, and who are not afraid to report them, will say something in the negative on this question."

But no one did.

Eddy currents of anger were generated by Dr. Brayton's comments but a rudder in action always generates eddies.

Dr. Brayton was an influential man. Born at Avon, New York, March 4, 1848, he attended Cornell University in 1871 and '72, then graduated from Butler University (B.S.) in 1878. He received the M.S. from Butler in 1880 and from I.U. in 1882. He also received the M.D. degree from the Medical College of Indiana in 1882 and the Ph.D. from Purdue University in 1885. His particular medical interest was dermatology.

He was professor of chemistry and toxicology at the Medical College of Indiana from 1883, later becoming professor of dermatology, syphilology and clinical medicine. He was vice-dean when the various medical schools united with I.U. School of Medicine, after which he continued as professor of dermatology and syphilology. He was editor of the *Indiana Medical Journal* from 1883 to 1907, and was president of the ISMA in 1902.

In addition to numerous medical articles, he was author of *Birds of Indiana*, *Mammals of Ohio*, and was co-author (with David Starr Jordan) of *Fishes of the Southern Allegheny Region*.

Dr. Brayton died Sept. 21, 1926 at the age of 78 years.

### THE CONSEQUENCES CAN BE LIFE-SHORTENING.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease...diabetes...hypertension... congestive heart failure...an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight—if, in fact, it is ever achieved.

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Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss:

THE RISK FACTOR **OBESITY PROGRAM** (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised sup-

plemented fast with long-term behavioral and nutritional training.

Under the supervision of the IHM medical staff, patients lose weight safely and consistently over a period of weeks and months. They receive their total daily nutritional requirements from a low-calorie egg albumen formulation and a multivitamin tablet... a supplement they stay with until goal weight is achieved.

### The success of the RFO Program has been significant.

Over the past five years, thousands of patients have lost from 25 to over 100 pounds. with the average loss being 63 pounds. More important, 75%\* of these patients have been able to sustain their new low weight levels with the help of our 18-month maintenance program.

Some have called the RFO Program "lifesaving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—



one we at IHM can help control.

To learn more about us and how this program can safely benefit some of your patients, please contact one of our medical directors at a clinic near you.

\*Data on file, Institute for Health Maintenance.

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# WHAT'S NEW?

The Du Pont Company is introducing a new analyzer for clinical laboratories and physicians' offices. It is the "aca" V. It features fast test results at lower cost than previous models. It includes a new test, that for blood serum level of digoxin. The reduction of operating costs and capital investment, and the ability to perform analysis outside the hospital fits in well with the federal prospective payment plan for hospitals.

Centocor, a maker of biological substances, announces FDA approval for marketing its Enzyme Immunoassay for the detection of Hepatitis B Surface Antigen. Centocor markets a Radio Immunoassay for Heptatitis B Surface Antigen. The Enzyme Immunoassay is preferred in some laboratories because it does not involve any radioactive substances.

Abbott Laboratories and Eli Lilly and Company have agreed to terms under which Lilly will make its intravenous (I.V.) drugs, including its line of injectable antibiotics, available in a new I.V. drug admixture system developed by Abbott. The new Abbott system, called ADD-Vantage, is designed for the intermittent I.V. administration of potent drugs that do not have long-term stability in solution. Like premixed I.V. drugs, ADD-Vantage will reduce hospital pharmacy costs by conserving labor, reducing material costs and minimizing drug waste. Premixes are drugs already dissolved in I.V. solutions when supplied to hospital pharmacies by manufacturers.

Smith Kline & French announces FDA approval for marketing "Monocid," the first once-a-day, injectable cephalosporin antibiotic in the U.S. Final approval, pending agreement on product labeling, is expected soon. The drug is well tolerated when given intravenously or intramuscularly. It has a broad spectrum of act vity against gram-positive and gram-1 egative organisms. Once-a-day dosage vill contribute to substantial savings in hospital costs due to decreased nurse duties and to the possibility of returning the patient to home care earlier because of the simpler medication schedule, and out-patient treatment.

The 3M Company has received FDA approval for marketing the 3M Cochlear Implant System (House Design). The device, which is the first cochlear implant to receive an FDA panel recommendation, provides sounds to a deaf person by electrically stimulating the inner ear. The user of the device is able to detect information-filled sounds such as fire engine sirens, car horns and doorbells, and can hear voices at normal conversational levels.

The Medical Division of Schell, Inc. has a new line of bags, handikits (Model 71424 and 71426), and Boston Bags (79206) with combination locks and staphCHEK® lining, all especially for medical uses. Combination locks eliminate keys and key loss. StaphCHEK® lining is waterproof, antibacterial, mildew-proof, provides odor control, resists stains and, if punctured, will not tear. If the lining is punctured it may be repaired with locally purchased vinyl adhesives.

**Upjohn** has FDA approval which will permit the sale of 200 mg. ibuprofen tablets as a non-prescription pain reliever. Bristol-Myers will be the sole distributor of the new product. It will be sold under Upjohn's trade-name NUPRIN tablets. Upjohn will manufacture the product for Bristol-Myers.

The Alberto-Culver Company has a replacement for salt, trade-named Mrs. Dash. Mrs. Dash is a blend of 14 herbs and spices and other natural flavors. Makes a delicious salt alternative for both cooking and as a table-top seasoning. Comes in two styles—the original and the new low-pepper, no garlic.

News of what is new in the medical supply industry is composed of abstracts from news releases by book publishers and manufacturers of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by INDIANA MEDICINE or by the Indiana State Medical Association.

Upjohn announces FDA approval for marketing Micronase Tablets (glyburide), a new oral, once-a-day anti-diabetes medication. Micronase Tablets are indicated as an adjunct to diet to lower blood sugar levels in patients with noninsulin-dependent diabetes (type II) whose elevated blood sugar levels cannot be satisfactorily controlled by diet alone. The new medication is not indicated for patients with insulin-dependent diabetes (type I) as sole therapy. Glyburide, the active ingredient in Micronase Tablets, has been available outside the United States since 1969 and is the most widely prescribed oral anti-diabetes medicine in the world.

The interactive graphics function of Hewlett-Packard's Coronary Angiography Reporting Station can now be performed with the HP 150 touch-screen personal computer. Offering a faster and simpler approach for documenting the findings of the coronary angiography procedure, this new capability reduces the price of the workstation by 40%.

Four new chemistry tests are now available for the ASTRA<sup>TM</sup> Automated Clinical Chemistry Systems from Beckman Instruments. These chemistries—triglycerides, cholesterol, uric acid, and phosphorus—were introduced in July. The tests may be run by discrete selection or simultaneously in combination with other tests on an ASTRA System.

A new system that permits patients to self-administer pain relieving drugs following surgery was introduced recently by Abbott Laboratories. Known as patient-controlled analgesia (PCA), the system assures patients more effective pain management, reduces hospital labor costs and results in more efficient drug use.

Midmark has introduced a new universal table for minor surgery and medical treatment. It is priced below electric and hand crank operated minor surgery tables. Its simplicity makes it easy and economical to maintain. It is identified as the 485 Surgi-Med Table and comes in four models.

INDIANA GAZETTE

# TALWIN®NX...BUILT-IN PROTECTION AGAINST MISUSE BY INJECTION

# Major Analgesic Reformulated

Now contains naloxone, a potent narcotic antagonist

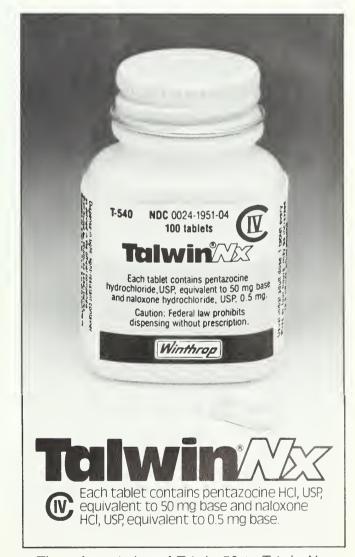
Extra security added to proven efficacy and safety

No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ\*, an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

\*Registered trademark of Ciba-Geigy Corp for tripelennamine.



The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.



# Talwin

Analgesic for Oral Use Only

Contraindications: Hypersure it vity

IALWIN Nx contents for can be out, Sector potential, ethal treating many as ult from occurs of IALWIN Nx b, opertion either shorter or combination with other substance. Free Drug Abuse and Dependence section

oper turn eithers. There or in combination with other substance. There Drug Abuse and Dependence section.

Warnings: Pring Dependence to an cause plays and and psychiliting except retence. (See Drug Abuse and Dependence 1 Head lights) and find a and Intra ratual Pressure. As with other potent in mapping, are paratory disposant to ffect of the drug may cleave the standard may be accorded to exapperated in the presence of head injury, other entre considerable some care the considerable some care to feets, alcohol should be used with caution Patients Receiving Narcotics. Pentazonine is a mild narcotic antagonist Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. Certain Respiratory Conditions. Should be administered with caution in respiratory depression from my care, severe bronchial asthn a and other obstructive respiratory conditions, or cyanosis Precautions: CNS Effect. Use nautiously in patients prone to Services, services have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disonentation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur Impaired Renal or Hepatic Function. Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairement in long-term use, precautions should be taken to avoid increases.

In long-term use, precautions should be taken to avoid increases in dose by the patient. Bihary Surgery. Some evidence suggests that unlike other narcotics pentazorine causes little or no elevation in bihary tract pressures, the Illinical significance of these findings is not yet known. Information for Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warend exit or express proposed the control of the patients. and occasional euphoria have been noted, ambullatory patients should be warned not to operate machinery drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressants. Myocradial Infarction—Use with caution in patients with myocardial infarction—Use have caution in patients with myocardial infarction—Use with caution in patients with myocardial infarction. Use with caution in patients with myocardial infarction who have nausea or vomiting. Drug—Interactions—Usage with Alcohol—See Warnings. Carcinogenesis, Mutagenesis, Impairment of Fertility. Nii—Ing-term studies in animals to test for carcinogenesis have been performed. Pregnancy Category C. Should be given to pregnant women only if clearly needed. Labor and Delivery. Use with caution in women delivering premature infants. Effect on mother and fertils, duration of labor or delivery needed for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and inscluding maturation of the child is unknown. Nursing Mothers Caution shill be exercised when administered to a nursing voman Pediatric Use. Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: Cardiovascular Hypotension, tachycardia synuopic Respiratory Rarey, respiratory depression CNS Acute CNS Manifestations in rare instances, hallucinations (usually visual), disorientation, and confus on which have cleared spontaneously within a period of hours, may recur if drug is reinstituted Other CNS Effects. Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement finitius, tremor Gastrontestinal. Nausea vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. Allergic Edema of the face, dermatitis, including printius, filiabed skin, including plethora. Ophthalmic: Visual biurring and focusing difficulty. Hematologic. Depression of white blood cells (especially granuloytes), which is usually reversible moderate transient eosinophilia. Other Headache chills insortina weakness, urinary retention.

Drug Abuse and Dependence: Controlled Substance. Dependence and withdrawal symptoms have been reported with urally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during appropriate him horse covered like proportions the expension of the dependence with

urally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported, there is no long-term experience with oral use of TALWIN Nx. The amount of naloxone pressent (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx. has a lower potential for parenteral missue than the previous oral pentazocine formulation, but is still subject to patient missue and abuse by the oral route. Severe, even lethal, consequences may result from missue of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion ulceration and abscenses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: Reatment. Dayge: intravenous fluids, vasopres in a distribution of the substances of tablets by the result of the patient may be a distributed as the substances. The patient of the patient may be a distributed as the considered in the supportive measures should be impleyed as individuals of the patient may be a perfect and effective antagonist clease consult full product information before prescribing.

Winthrop-Breon WIN 4-41415E

Wirthing Breon Laboratories Division of Sterling Drug Inc New York NY 10016

### How well are you communicating with your PATIENTS?



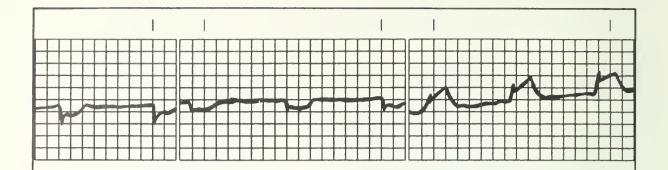
Patient compliance—how well patients follow instructions about taking prescription drugs—is something that worries health professionals, according to a recent Harris survey. And with good reason. A number of studies have shown that a third to a half of all drugs are taken improperly. Yet a Chilton survey found that only 2 to 4 percent of patients question their doctors about drugs prescribed for them.

It's up to health-care providers to open up the dialogue about prescription drugs. When you write, dispense or check on a prescription, make sure your patient knows:

- The name of the drug
- Its purpose—what conditions does it treat?
- How and when to take the drug—and when to stop taking it
- What food, drinks and other drugs to avoid while taking it
- What side effects may result—are they serious, short-term, long-term, etc.?
- A message from the Food and Drug Administration.

# Everything you need to manage your one-to-four-doctor office!





# This misread EKG delayed the patient's admission & treatment—and cost the doctor a malpractice claim.

The doctor who read this EKG diagnosed the patient's nausea as being due to gastroenteritis and sent her home. Six hours after being admitted the next day, the patient expired of an acute MI.

The result: A malpractice claim against the physician.

Recent national evidence, and information from our own claims files, suggests that MIs are frequently misdiagnosed. The EKG above, for example, strongly indicates an acute MI.

We know that insurance coverage alone won't solve the malpractice problem. It will also take reasonable patient expectations. And even greater diligence by physicians.

That's why our medical directors review hundreds of cases each year. Their jobs: To spot problem areas or emerging trends and warn policyholders, through timely publications, medical/legal seminars and other educational presentations.

So if you're looking for thorough insurance protection *PLUS* valuable information on avoiding potential malpractice traps, look into coverage from *Pennsylvania* Casualty Company.

See your insurance agent/broker, or contact us at the address below.



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Today, in the High-Tech Computer Age, it is too easy to forget special groups of people who need medical attention.

House Call Physicians, Inc. is a group of Indianapolis-based physicians who are dedicated to bringing quality medical care to the home, institution, and workbound patient.

### The patients we reach are:

- bedridden or shut-in
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- chronically or terminally ill
- nursing home tenants
- persons needing care after office hours and on weekends
- tourists and travelers
- pediatric and geriatric patients

We can suture minor wounds and care for many minor medical ailments. We can do EKG's, portable x-rays, physical exams, draw laboratory specimens and dispense medicines (NO NARCOTICS).

### WE CAN BE OF BENEFIT TO THE PERSONAL PHYSICIAN WHEN HE OR SHE:

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- is out of the office.
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- is too booked to see a patient within a reasonable time frame
- cannot attend a chronically or terminally ill patient who needs ongoing physician evaluation and treatment but wishes to remain outside the confines of a hospital
- requires qualified evaluation, treatment and detailed information on his/her patient at their home

House Call Physicians, Inc. is not seeking patients for long-term care. We will assist chronically and terminally ill patients under the direction of their personal physician. We would prefer that all patients seeking our aid would first contact their personal physician. Patients not having a personal physician are referred to local physicians for follow-up.

HOUSEGALL PHYSICIANS, INC. 3561 NORTH PENNSYLVANIA ST. INDIANAPOLIS, IN 46208 317/923-Dr. Dr. 317/923-3737

# FUTURE FILE

### **Evansville Seminars**

The fall seminar schedule for St. Mary's Medical Center, Evansville, opens Sept. 20 at 1 p.m. with the Joseph E. Coleman Pediatric Seminar on "Learning Disabilities."

The Endocrine Seminar (Part V—The Pituitary Gland) will meet at 1 p.m., Oct. 18. The Family Practice Seminar (Type 1I Diabetes) will meet at 1 p.m., Nov. 15.

The September and October programs will be held in the Amphitheatre; the November meeting is at the Executive Inn

For more information, call the hospital at (812) 479-4468.

### Controversies in Medicine

"Controversies in Medicine" is the subject of a medical meeting to be held Friday, Nov. 9, in Birmingham, Alabama.

Organ Transplants, Rationing Medical Care, Aging Process-Control, Genetic Engineering, Endoscopy-Emergency, and First-Aid and Paramedics: A Plus or a Minus will be the main subjects. The fee will be \$65. CME credit will be for seven hours Category 1 (AMA).

The meeting will be in Cudworth Hall-University of Alabama in Birmingham, 1917 8th Ave., South (adjoining Birmingham Hilton). The correspondent is Dena Metts (phone 205/250-7703).



"So many people wear old clothes to make an impression on me—I thought I'd see what kind of impression it makes on them,"

The Journal of the American Medical Association publishes a list of CME courses for the United States twice yearly. The January listing features courses offered from March through August; the July listing features courses offered from September through February.

### Cincinnati Conferences

Three conferences sponsored by Cincinnati's Bethesda Hospitals scheduled for this fall involve neurotrauma, lung cancer and computers.

A neurotrauma conference will be held Sept. 29 and 30 at Bethesda Oak Hospital for emergency physicians and primary care physicians. The course will cover emergency management of head and neck injuries, current techniques for managing neurotrauma in the emergency setting, and treatments of choice for stroke and low back pain patients. Registration is \$195.

Lung cancer is the focus of the Cincinnati Cancer Conference 111, scheduled for Nov. 2 and 3 at the Hyatt Regency in Cincinnati.

Finally, "Computers in Health Care & Practice Management" is the topic of a conference scheduled for Nov. 16, 17 and 18 at the Hyatt Regency. Speakers will discuss the economics of medical office computers. Registration is \$50.

For more information, contact Thomas J. O'Connor, Bethesda Hospital, 619 Oak St., Cincinnati, Ohio 45206—(513) 569-6339.

### Infectious Disease

A "Symposium on Infectious Disease: Diagnosis and Treatment in Office Practice," sponsored by Indiana University, will be held at the Radisson Hotel, Indianapolis, on Sept. 22.

It is accredited for six prescribed hours by the AAFP and for six hours by the AMA. There is no registration fee as the meeting is supported by a grant from Eli Lilly and Company.

Direct inquiries to Jonathan P. Murray, Project Director, Center for Healthcare Communications, 420 Lexington Ave., Suite 320, New York, N.Y. 10017—(212) 210-8940.

### **Alcoholic Emergencies**

"Practical Management of Psychiatric and Alcoholic Emergencies" will be the subject of a conference Thursday, Oct. 25, at Howard Community Hospital, Kokomo.

The program, co-sponsored by the hospital and Indiana University School of Medicine, is for family physicians and emergency room physicians.

To register, contact Bev Woodard, Howard Community Hospital, 3500 S. LaFountain St., Kokomo, Ind. 46902—(317) 453-0702.

### CME Calendar

CME meetings announced by the Methodist Hospital of Indiana are as follows:

Sept. 7—"Cardiac Transplant Symposium" at Adam's Mark Hotel, Indianapolis.

Sept. 14 & 15—"Annual Midwest Neuro Critical Care Seminar II," Clarion Hotel, Cincinnati.

Sept. 20 & 21 (tentative)—"Noninvasive Technology Diagnosis and Evaluation of Cardiac and Vascular Disorders," at Methodist Hospital-Medical Tower, Indianapolis.

Sept. 21 & 22—"Horizons in Management of Ophthalmic Problems," at Radisson Plaza Hotel, Indianapolis.

Oct. 12—"Hemodynamic Monitoring: State of the Art," at Methodist Hospital, Indianapolis.

Oct. 17 (tentative)—"Obesity Control: Failure 1s Not Inevitable," at Methodist Hospital-Medical Tower, Indianapolis.

Oct. 18 & 19—"Annual Fall Wishard Lecture."

Nov. 2 & 3—"Advanced Trauma Life Support" (Provider Level), at Methodist Hospital, Indianapolis.

Nov. 30 & Dec. 1—"Cataract Surgery Seminar and Basic Technique Update," at Radisson Plaza Hotel, Indianapolis.

Nov. 28—"Third Annual Symposium on Ethical and Moral Issues."

Further information is available from Dixie Mattingly, CME Coordinator, Methodist Hospital, 1604 N. Capitol Ave., Indianapolis 46202—(317) 929-3733.

### **Clinical Nutrition**

"Challenges for Clinical Nutrition in the Eighties" is the title of a postgraduate course to be conducted Sept. 10-11 by the American Society for Parenteral and Enteral Nutrition at the Marriott Pavillion Hotel in St. Louis, Mo.

Contact ASPEN, 1025 Vermont Ave., N.W., Suite 810, Washington, D.C. 20005—(202) 638-5881.

### **Oncology Nursing**

"Oncology Nursing Conference VI" will be sponsored by the Department of Nursing at the University of Texas M. D. Anderson Hospital and Tumor Institute at Houston Sept. 12 to 14 at the Hyatt Regency Hotel Downtown.

Write or phone Office of Conference Services, Box 131, M.D. Anderson Hospital, 6723 Bertner Ave., Houston 77030—(713) 792-2222.

### **Pediatrics Symposium**

The 12th annual Fall Pediatric Surgery/Pediatrics Symposium concerning "Care of the Seriously Ill Child" will be held at the Indianapolis Radisson Hotel, Keystone at the Crossing, Oct. 10-11. The symposium will be sponsored by the Indiana University School of Medicine.

Contact Jay Grosfeld, M.D., Riley Hospital, 702 Barnhill Drive, 1ndianapolis 46223—(317) 264-4681, or Joni Downs—(317) 264-8353.

### Newborn Symposium

"Cardio-Respiratory Problems in the Newborn" will be the theme of the 18th Annual Newborn Symposium to be conducted by the Pediatrics Department of the University of Louisville School of Medicine Nov. 1-2. Category 1 credits will be allowed.

Contact Billy F. Andrews, M.D., Kosair-Children's Hospital, University of Louisville, Louisville 40292—(502) 562-8826.

### Anesthesiologists to Meet

The American Academy of Clinical Anesthesiologists will conduct its fall seminar Oct. 24 to 27 at the Grove Park Inn, Asheville, N.C.

For more information on the seminar, accredited for 11 AMA Category 1 hours, contact the AACA, P.O. Box 11691, Knoxville, Tenn. 37939—(615) 588-6279.

### Four Days in Mexico

The 32nd annual convention of the Medical Society of the United States and Mexico will convene Nov. 14-17 in Guadalajara, Jalisco, Mexico.

For information, contact Kevin Walker, Executive Secretary, Medical Society of the United States and Mexico, 810 W. Bethany Home Road, Phoenix 85013—(602) 246-8901.

### Managing Strokes

"Diagnosis and Management of Strokes" is the title of a CME program scheduled for Oct. 12 and 13 at Madison, Wisc.

The program, sponsored by the University of Wisconsin School of Medicine, will feature internationally and nationally known stroke experts. AMA Category 1 credit is 11 hours.

Contact Sarah Aslakson, 465B WARF Bldg., 610 Walnut St., Madison, Wisc. 53705—(608) 263-2856.

### Medical Oncology

The seventh annual Topics in Medical Oncology meeting will be conducted Tuesday, Nov. 20, at Highlands Baptist Hospital, Louisville.

"The Costs and Dilemmas of Cancer and Cancer Care" will be the topic of morning and afternoon sessions, while "Systemic Coagulation Problems in Malignant Diseases" will be discussed in the evening. The fee is \$25, which includes lunch, breaks and educational handouts.

Contact Barbara Janes, Cancer Registrar, Highlands Baptist Hospital, 810 Barret Ave., Louisville, Ky. 40204—(502) 561-3100.

### **ASIM Annual Meeting**

The American Society of Internal Medicine will hold its annual meeting Sept. 20-23 at the Hilton Palacio Del Rio Hotel in San Antonio.

The theme of the meeting will be "Transitions and Transactions." Program sessions will focus on "Medicine, Society and the Dying Patient: The Case of Granny Doe" and "The New Era of Negotiations."

### Seminars in Pediatrics

"Seminars in Pediatrics" will be conducted Oct. 12-13 at the Clinical Science Center, University of Wisconsin at Madison.

AMA Category 1 credit is 10 hours. Fees are \$100 for physicians, \$65 for nurses.

Contact Sarah Aslakson, 465B WARF Bldg., 610 Walnut, Madison, Wisc. 53705—(608) 263-2856.

### **Lung Cancer**

"Lung Cancer" will be the subject of the Cincinnati Cancer Conference III, to be held Nov. 2-3 at the Hyatt Regency in Cincinnati.

For details contact Thomas J. O'Connor, Bethesda Hospitals, 619 Oak St., Cincinnati 45206—(513) 569-6337.



"I'm not so worried about not making ends meet as I am about the length of the gap in between."

### WILLIAM M. DUGAN, JR., M.D.

Clinical Oncology Center Methodist Hospital of Indiana, Inc.

# CANCER CORNER

New information from Indiana Division American Cancer Society, Inc. 4755 Kingsway Dr., Suite 100 Indianapolis 46205

EVERY PHYSICIAN'S OFFICE— A CANCER DETECTION CENTER

### Road to Recovery

Road to Recovery is a new approach to an important American Cancer Society direct patient service program that has actually been around for a long time—patient transportation. By driving cancer patients to and from medical facilities for treatment, volunteers will be assisting literally to help cancer patients along the "road to recovery."

The Road to Recovery volunteer transportation program was developed and conducted by the Massachusetts Division of the American Cancer Society. Success of this pilot program was so great that it has been adopted by the American Cancer Society as a national program.

Since cancer therapy often goes on for an extended time, many patients are in need of transportation to and from treatments. For example, one cancer patient requiring radiation therapy could need 20 to 30 treatments during six weeks, and a patient receiving chemotherapy might report for treatment weekly for up to a year. In many cases, a patient is driven to hospitals or clinics by relatives or friends, but even these patients must occasionally seek alternative transportation. That's where Road to Recovery comes in.

In the Massachusetts pilot program the average age of the Road to Recovery volunteer was 54. Many were retired people who like to keep busy and feel useful, but many volunteer drivers were young and employed. In fact, some worked for companies that participated in Road to Recovery by allowing employees "released time" to drive for the program. These employers even loaned company cars and vans for patient transportation. It was also discovered that many people volunteer to drive because they have had some personal experience with cancer and they know what an absolute necessity this program is. But others do it just for the satisfaction they get in helping others... in doing something extra for someone who needs it.

There is a road. Many cancer patients need transportation to and from treatments. That's why the American Cancer Society has formed groups of volunteers across the United States who give a few hours of their time each month to drive them. The road to recovery can be a long and difficult one, but it can be that much easier when there are friends who. can help along the way. American Cancer Society

The Indiana Division of the ACS has already completed the initial training state-wide of volunteer Road to Recovery coordinators. The society hopes to recruit 1,500 drivers state-wide. The main driver recruitment efforts have been taking place this summer. All drivers will be screened and trained by ACS volunteers.

Further information may be obtained through your local American Cancer Society office or by contacting John Kirby, director of communications, or Betsy Brolin, medical affairs director, at the Division Office, 317/872-4432.

Road to Recovery will make a tremendous difference in the lives of cancer pa-

tients and the lives of their families. There is a road for many—there is a cure.

### Preview of the 1984 Smokeout

DATE: November 15, 1984— NATIONAL CHAIRMAN: LARRY HAGMAN

### **NEW MATERIALS:**

Adopt a Smoker/Help a Friend Quit Poster. Adapted from the California Division. It features two humorous cartoon figures who illustrate the adoption concept in a warm, friendly way. This will replace last year's Uncle Sam poster and will supplement the standard GAS poster.

GAS Survival Kits. Small plastic bags featuring the GAS logo, ready for local stuffing with quit tips, lollipops, carrot sticks, Larry Hagman Red Rubber Bands, etc. Ideal for adopters to give adoptees.

RX Pad for Physicians. Prescription: Quit Smoking-Nov. 15. Studies show most smokers would quit if their doctors would only advise them to. This will help stimulate increased involvement of the medical profession in the Smokeout. This idea was adapted from the Utah Division.

**Headless Matches.** A possibility awaiting results of informal Division survey.

Generic GAS Envelopes. A large white envelope, a little larger than Company/ School Kit size, undated. For sending GAS materials.

As you can judge from the above, we will be continuing strong with the Adopt A Smoker theme. Adoption certificates will be made undated from now on, and new Adopt A Smoker stickers have been designed.

WOED SPECIAL. At 9 p.m. EST on November 14, the eve of the smokeout, "Breathing Easy" will air. The one-hour special will be an entertaining antismoking program aimed at teenagers. It will be originated by WOED in Pittsburgh with substantial funding from ACS. It will be aired on the PBS System nationwide. Details will follow.

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Medical Society and Hospital References Available On Request

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# An Ounce of Prevention

The eight points of good advice reproduced below are from an advertisement that appeared in the Bulletin of the Medical Society of the County of Kings and the Academy of Medicine of Brooklyn, New York. They constitute good rules for the practice of medicine and would be valuable even in the absence of the dangers of malpractice lawsuits. They are reproduced with permission of the Medical Liability Mutual Insurance Company and the Medical Society of the County of Kings as an addition to the educational program of the Physicians Insurance Company of Indiana.

Brief elaborations of each of the eight points will be published, one at a time, in future issues of INDIANA MEDICINE.

- 1.) Be cognizant of the need to establish a good relationship with your patients, taking the time to listen to their complaints and empathizing with them.
- 2.) Do not create unreasonable expectations about the results of treatment.
- 3.) Be aware of the necessity of communicating to your patient, in simple layman's language, the generally recognized risks and complications of the methods of treatment you recommend and alternative modes of treatment. Further, you should make a note in your record to the effect that you have given the patient such information.
- 4.) Carefully review at frequent intervals your patient case load to insure that your volume of work does not make it difficult to devote adequate time to each patient.
- 5.) When involved in the care of a patient with other physicians, make sure that there is a clear delineation of responsibility for overall management of the patient's condition.
- 6.) In surgical cases, you should write a pre-operative note documenting your findings and proposed treatment.
- 7.) You should carefully monitor your methods for collecting overdue accounts. No action should be taken to collect a bill until you have reviewed all of the circumstances.
- 8.) Be sure to seek consultation in difficult cases.

# T. S. DANIELSON, JR., M.D., M.P.H. Acting State Health Commissioner

New information from Office of the Commissioner Indiana State Board of Health 1330 W. Michigan St. Indianapolis, Ind. 46206 317-633-8400

# PUBLIC HEALTH HOTES

### WIC Celebrates 10th Anniversary

Ten years ago the Special Supplemental Food Program for Women, Infants and Children—popularly known as WIC—began as a small national program to provide nutrition assistance to low-income women and children during critical phases of development. Today, the program is operated by I,500 local agencies at more than 7,000 sites throughout the United States.

The Indiana WIC Program, administered by the Indiana State Board of Health and operated locally by various health and human service agencies, has shared in WIC's successful growth this past decade.

In 1974, the Indiana WIC program provided benefits to I,169 high-risk pregnant women in one county and one city of our state; I0 years later, WIC benefits are available to 60,000 participants each month. These participants live in 80 different counties and receive their WIC services through 42 local agencies operating I06 sites.

One of six babies born in Indiana in 1983 was a WIC baby. The low-income population of Indiana is being reached as 80% of the WIC caseload earns an income below the official poverty level even though WIC is available to persons earning up to 185% of poverty.

The goal of the Indiana State Board of Health is to have all 92 counties of Indiana offer WIC services. Reaching this goal is dependent upon increased federal funding, since state support is not provided.

Through WIC, pregnant and postpartum women, nursing mothers and children from birth to age 5, who are at nutritional risk, receive supplementary foods of high nutritional value, nutrition education and linkages with health services. WIC is unique among food assistance programs in that it is the only program that screens applicants for nutritional need and integrates food, nutrition services, and health care for our country's most nutritionally vulnerable group.

Typically, a physician, nutritionist or nurse screens WIC applicants for nutritional need to determine eligibility. A hemoglobin, height, weight, health history and food intake record provides the data for the nutritional assessment. Certification for the program lasts for six months for children, postpartum and nursing mothers, or for the duration of a woman's pregnancy. At the end of the certification period, the participant may reapply for program benefits.

The supplemental foods offered by WIC are high in protein, calcium, iron and vitamins A and C. These are the nutrients found to be deficient in WIC's target population. A nutritionist or nurse determines the nutritional need of each participant and prescribes a monthly food package based on approved WIC foods.

The WIC program encourages breast-feeding; however, infants who are bottle-fed may receive iron-fortified formula, cereal and juices high in vitamin C. Women and children may receive milk, cheese, eggs, cereals high in iron and low in sugar, peanut butter or dried beans, and fruit juice high in vitamin C.

Nutrition education is an integral component of WIC and is often given the greatest amount of credit for the success of the program. WIC nutritionists and nurses strive to teach the relationship between good nutrition and good health, help participants develop better eating habits, and show them how to make the best use of WIC-provided foods to supplement their diets. It is WIC's philosophy to help participants become healthier and more self-sufficient through education and application.

While routine medical care is not provided by WIC, all participants are encouraged to seek and continue medical guidance. Many participants have private physicians and continue as patients of their physicians while enrolled in WIC. Cooperation and communication between health care providers and the WIC professional staff are encouraged so as to best serve the interest of the individual.

### WIC Gets Results

In a short decade, the WIC program has significantly improved the health and nutritional status of millions of women and children. Studies of WIC participants have shown positive trends in the reduction of both neonatal mortality and the incidence of low birth weight infants. An important finding is that mean birth weight increases with the increased length of WIC participation.

Low birth weight has long been associated with a higher frequency of developmental abnormalities, increased medical costs and longer hospital stays. An evaluation done at the Harvard School of Public Health in 1979, and another more recent evaluation by the Missouri Department of Health, suggests that WIC is cost-effective in terms of its potential to reduce medical costs associated with low birth weight. A WIC food package costs approximately \$28 a month or \$200 for seven months of pregnancy. The cost for a low birth weight infant to gain one pound of weight in a neonatal intensive care unit has been estimated at \$12,000. Savings also accrue to Medicare, special education and disability programs because low birth weight is associated with blindness, deafness and mental retardation.

Other studies show infants and children participating in WIC have decreased rates of anemia and an accelerated rate of growth. Research published in 1982, in the *Journal of Public Association*, has also suggested that WIC may be contributing to improved mental performance by participants.

WIC has expanded rapidly in the past 10 years. This growth is directly attributable to the physicians, nutritionists and other health and social services professionals who have provided support at the community level. The decade ahead holds even stronger promise for an even greater program as we build upon and fine tune the basic components of WIC.

# BALANCED CALCIUM CHANNEL BLOCKADE!



### Low incidence of side effects

CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

### References:

- 1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
- Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exerciseinducible chronic stable angina with diltiazem: Effect on treadmill exercise. <u>Chest</u> 78 (July suppl):234-238, 1980.

# Reduces angina attack frequency\* 42% to 46% decrease reported in

42% to 46% decrease reported in multicenter study.

### Increases exercise tolerance\*

In Bruce exercise test, control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes (P<.005).

# **CARDIZEM**

(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

### PROFESSIONAL USE INFORMATION



DESCRIPTION

(diltrazem hydrochloride) is a calcium ion influx CARDIZEM\* inhibitor (slow channel blocker or calcium antagonist). Chemically, diffiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:

Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral

### CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed

attacking the following ways:

1. Angina Due to Coronary Artery Spasm. CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary arteries both coronary arteries both coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary arteries between the coronary arteries are specifically as the coronary arteries between the coronary arteries are coronary arteries and coronary arteries are coronary arteries.

onary artery spasm are inhibited by CARDIZEM.

2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH

interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of dilitazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by dilitazem. or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 30D mg of CARDIZEM in six normal volunteers, the average maximum PA prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus

cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three

usually produced anomal prioringation. There were, nowever, finite instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Dilitazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40% CARDIZEM undergoose sytemsive hostic metabolism is when you will be a subject to a sytem of the production of the subject of the sub undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 3D to 12D mg of CARDIZEM result in detectable plasma levels within 3D to 6D minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl dititazem is also present in the plasma at levels of 1D% to 2D% of the parent drug and is 25% to 5D% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CORDIZARY VASOURLED AS URREADER. THE PROPERTY ASSUMED TO EVERS OF CARDIZERM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given, a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem

### INDICATIONS AND USAGE

1. Angina Pectoris Due to Coronary Artery Spasm. CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

Chronic Stable Angina (Classic Effort Associated Angina).
CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduc tion abnormalities

### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

 Cardiac Conduction. CARDIZEM prolongs AV node refrac-tory periods without significantly prolonging sinus node recov-ery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 6D mg of dittazem.

Congestive Heart Failure. Although dittazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic

studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.

**Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension

Acute Hepatic Injury. In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

### **PRECAUTIONS**

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In sub-acute and chronic dog and rat studies designed to produce toxicity, high doses of dilitazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs,

doese of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing **Drug Interaction**. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltrazem has been shown to increase serum digoxin levels up to 20%

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 2D times the human dose or greater

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established

### **ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presenta tion corresponding to the relative frequency of occurrence

Flushing, arrhythmia, hypotension, bradycar-Cardiovascular

dia, palpitations, congestive heart failure.

syncope. Paresthesia, nervousness, somnolence

Nervous System tremor, insomnia, hallucinations, and amnesia.
Constipation, dyspepsia, diarrhea, vomiting Gastrointestinal mild elevations of alkaline phosphatase, SGOT

SGPT and LDH

Pruritus, petechiae, urticaria, photosensitivity Dermatologic: Polyuria, nocturia. Other

The following additional experiences have been noted A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM

The following postmarketing events have been reported infre-quently in patients receiving CARDIZEM erythema multiforme, leu-kopenia, and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 3DD mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia Administer atropine (0.60 to 1.0 mg). If there is no response to varial blockade, administer

isoproterenol cautiously.

Treat as for bradycardia above. Fixed high-

degree AV block should be treated with car diac nacing.

Administer inotropic agents (isoproterenol, Cardiac Failure donamine or dobutamine) and diuretics Hypotension Vasopressors (eg. dopamine or levarterenol

bitartrate).

High-Degree AV

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating

clinical situation and the judgments are greatly stated. The oral/LD<sub>so</sub>'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD<sub>so</sub> sin these species were 60 and 38 mg/kg, respectively. The oral LD<sub>so</sub> in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

### DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atheroscierotic Coro-nary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Disease or Anglina Pectoris at Rest Due to Coromary Artery Spasm. Dosage must be adjusted to each patient's 
needs. Starting with 3D mg four times daily, before meals and at 
bedtime, dosage should be increased gradually (given in divided 
doses three or four times daily) at one- to two-day intervals until 
optimum response is obtained. Although individual patients may 
respond to any dosage level, the average optimum dosage range 
appears to be 18D to 240 mg/day There are no available data concerning dosage requirements in patients with impaired renal or hepatic 
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in the property function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. Sublingual NTG may be taken as required to abort acute anginal attacks during CARDIZEM therapy

2. Prophylactic Nitrate Therapy—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal

effectiveness of this combination.

Beta-blockers. (See WARNINGS and PRECAUTIONS.)

### **HOW SUPPLIED**

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC DB8-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0D88-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC DD88-1772-47) and in Unit Dose Identification Paks of 100 (NDC DD88-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

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# Aspiration Biopsy Cytology: Biopsy Method of the Eighties

MICHAEL D. GLANT, M.D. Indianapolis

HE TECHNIQUE OF Aspiration Biopsy Cytology (ABC) was developed in 1930¹ but its utility was largely unappreciated until the Swedish began to employ it in the 1950s.² Its popularity in Sweden has increased to the point where over 40,000 ABCs are performed each year, as compared with 10,000 conventional surgical biopsies. Frable³ and others ⁴.5.6 have reported their success with this procedure in recent years.

ABC is based on a simple concept. A small needle is inserted into a lesion, and

negative pressure is used to aspirate a slurry of cells and tissue fragments into the needle lumen. This material is then smeared on a slide for microscopic examination. However, the accuracy of diagnosis critically depends upon specific details of the collection and preservation techniques and the knowledge and experience of the cytopathologist interpreting the slides. In both Europe and America, experience has shown the greatest success when the cytopathologist personally obtains the sample or closely assists the individual obtaining the sample.

At Indiana University Medical Center, ABC was not used frequently until the author, a cytopathologist, became particularly interested in this technique. As our physicians have become more aware of this method's ready availability and its advantages, there has been a dramatic increase in interest. In 1983, over 1,000 ABCs were performed, about as many as had been accomplished in the previous

four years. The author actively participated in both the procurement and processing of approximately two-thirds of the slightly more than 2,000 ABCs reported in this article.

### The Method

An exhaustive discussion of the method is beyond the scope of this article, but a general description may be of interest to the reader. The skin overlying the lesion is numbed with lidocaine, then a 25 gauge needle on a 20 ml syringe is inserted into the lesion, using a one-handed pistol grip on the syringe so that the other hand is free to palpate. Needle and syringe sizes are usually varied for the particular clinical situation, and also the strength of suction. The suspension of cells and "microbiopsy" tissue fragments collected are very easily destroyed or lost by dilution with blood or improper handling.

A drop or two of the aspirate is placed between two plain glass slides, and the

The author is Medical Director, Cytopathology, and Associate Professor, Dept. of Pathology, Indiana University School of Medicine, University Hospital, N340, 1100 W. Michigan St., Indianapolis, Ind. 46223.

slides are gently pulled in opposite directions to spread the material. One slide is rapidly fixed in 95% ethanol for a Papanicolaou stain, and the other is airdried (Diff-Quik® stain). This procedure is usually repeated 3-5 times with additional needles, to get a representative collection of biopsy specimens from the lesion. If indicated, biopsy material for special stains, electron microscopy, and other procedures is also obtained. When aspirates are guided radiologically, airdried slides are reviewed immediately for their quality, and the number of samples taken is determined on this basis. It should be noted that needle track seeding of malignancies has not been seen with this technique, in spite of routinely obtaining multiple biopsy specimens.

We use a standard reporting terminology which provides our estimate of the confidence level of the diagnosis as compared to an adequate surgical biopsy. When the diagnosis is said to be definite, the diagnosis is equal to an adequate surgical biopsy, with less than a 1% sampling/interpretive error. If a cellular pattern is described as "consistent with" a certain diagnosis, then it is slightly less reliable than an adequate surgical biopsy (4% or less sampling/interpretive error). Occasionally, a cellular pattern is only "suggestive of" a certain diagnosis which indicates lower reliability (10-30% sampling/interpretive error). However, even the latter category of diagnosis usually provides information which helps with the selection of further tests and therapy.

As previously noted, an ABC specimen consists of a mixture of isolated cells or small cell groups and small tissue fragments. It is the author's view that a cytopathologist has the optimal background for working with ABC, in view of training in both exfoliative cytology and surgical pathology techniques and interpretation. This background, plus an eye for three dimensional structure and the opportunity to learn by correlating ABC results with surgical specimens and clinical follow-up, eventually allows reliable diagnosis with this technique.

Our techniques have inevitably evolved

TABLE 1

Aspiration Biopsies 1978-82
Indiana University Medical Center Hospitals

	POSITIVE		NEGATIVE		CLINICAL or HISTOLOGY	FALSE	FALSE			
SITE	CASES	DX	NON-DX	BENIGN	INADEQ	CORREL	POSITIVE	NEG		
Thyroid	150	13 <sub>(9)</sub>	33 <sub>(22)</sub>	78 <sub>(52)</sub>	26 <sub>(17)</sub>	38 <sub>(25)</sub>	6(4)	1(0 6)		
Breast	207	35 <sub>(17)</sub>	11 <sub>(5)</sub>	150 <sub>(73)</sub>	11 <sub>(5)</sub>	142 <sub>(68)</sub>	5 <sub>(2)</sub>	3 <sub>(1)</sub>		
Other Palpable	235	115 <sub>(49)</sub>	9(4)	79 <sub>(33)</sub>	32 <sub>(14)</sub>	94 <sub>(40)</sub>	1 <sub>(0 4)</sub>	9(4)		
Thoracic	156	65 <sub>(43)</sub>	21 <sub>(13)</sub>	49(31)	21 <sub>(13)</sub>	35 <sub>(22)</sub>	2 <sub>(1)</sub>	2 <sub>(1)</sub>		
Ab- dominal	118	57 <sub>(48)</sub>	2 <sub>(2)</sub>	33 <sub>(28)</sub>	26 <sub>(22)</sub>	30 <sub>(25)</sub>	0	0		
Gyne- cologic	246	79 <sub>(32)</sub>	35 <sub>(14)</sub>	102 <sub>(42)</sub>	30 <sub>(12)</sub>	237 <sub>(96)</sub>	1(0 4)	39 <sub>(16)</sub>		
Other	15	6(40)	1 <sub>(7)</sub>	3 <sub>(20)</sub>	5 <sub>(33)</sub>	4(27)	0	2 <sub>(13)</sub>		
Totals	1127	370	112	494	151	580	63	15		
% of Total	100%	33%	10%	44%	13%	52%	1.3%	5.6%		
( ) = percent of total in each site										

Diagnoses are listed POSITIVE if the ABC diagnosis was definitely malignant (DX = diagnostic) or had features consistent with malignancy (NON-DX = non-diagnostic). NEGATIVE ABC

diagnoses include non-malignant cases with adequate cellularity (BENIGN) and cases with inadequate cellularity (INADEQ. = inadequate). CLINICAL or HIST-OLOGY CORRELATION lists the

over the past four years as we have gained increasing experience with ABC. Our approach has changed most in the areas of procurement and processing; the eventual interpretation heavily depends upon properly prepared specimens. *Tables 1 and 2* compare our 1983 experience, after procurement and processing methods have stabilized, and our prior experiences during the 1978-82 period. Overall accuracy has increased and the incidence of false-positives and false-negatives has decreased.

The following sections discuss the technique's results, utility and limitations for several body sites of particular interest.

### Thyroid

The great majority of thyroid nodules are benign adenomas, cysts or nodular portions of a colloid goiter, but some are thyroid carcinomas. Most thyroid carcinomas are treated by surgical removal. It is preferable to triage thyroid nodules so that malignancies can be detected for surgical excision, but individuals with benign nodules should be spared the necessity of surgery whenever possible. Thyroid scans can only definitely exclude carcinoma in the 5% of cases where hot nodules are found. Ultrasound can identify whether a nodule is solid or cystic; a pure cyst is most frequently benign, but up to 30% of carcinomas are known to

TABLE 2

Aspiration Biopsies 1983
Indiana University Medical Center Hospitals

		POSITIVE		NEGATIVE		CLINICAL or	EAL CE	EALCE.
SITE	CASES	DX	NON-DX	BENIGN	INADEO.	HISTOLOGY CORREL.	FALSE POSITIVE	FALSE NEG.
Thyroid	84	7 <sub>(8)</sub>	14(16)	61 <sub>(74)</sub>	2 <sub>(2)</sub>	8 <sub>(10)</sub>	0	0
Breast	316	52 <sub>(17)</sub>	21 <sub>(7)</sub>	239 <sub>(75)</sub>	4(1)	102 <sub>(32)</sub>	3 <sub>(1)</sub>	3 <sub>(1)</sub>
Other Palpable	344	147 <sub>(43)</sub>	18 <sub>(5)</sub>	144(42)	35 <sub>(10)</sub>	113 <sub>(33)</sub>	0	3 <sub>(1)</sub>
Thoracic	85	43 <sub>(51)</sub>	5 <sub>(6)</sub>	32 <sub>(37)</sub>	5 <sub>(6)</sub>	20 <sub>(24)</sub>	1(1)	4 <sub>(5)</sub>
Ab- dominal	94	55 <sub>(59)</sub>	4(4)	30 <sub>(32)</sub>	5 <sub>(5)</sub>	24 <sub>(26)</sub>	0	2 <sub>(2)</sub>
Gyne- cologic	84	30 <sub>(36)</sub>	6 <sub>(7)</sub>	31 <sub>(37)</sub>	17 <sub>(20)</sub>	24 <sub>(29)</sub>	0	3 <sub>(4)</sub>
Other	8	6 <sub>(74)</sub>	0	1 <sub>(13)</sub>	1 <sub>(13)</sub>	3 <sub>(38)</sub>	0	0
Totals	1015	340	68	538	69	294	4	15
<pre> % of Total</pre>	100%	34%	7%	53%	7 %	29%	0.4%	1.5%

number of cases in which correlative information was available from a surgical biopsy (or in the case of gynecologic or breast lesions, clinical follow-up for at least 6 months), and the diagnoses agreed

with ABC. FALSE-POSITIVE and FALSE-NEGATIVE numbers refer to those cases in which similar correlative information was available, but the diagnoses differed from ABC.

have large areas of cystic degeneration, and this can result in some uncertainty. Serum hormone studies are rarely helpful in separating benign from malignant lesions.

Thyroid ABC presents some specific technical problems. Since the majority of thyroid nodules are benign and most benign tissues do not release many cells on aspiration, samples are frequently scanty. The thyroid gland is very vascular and aspiration frequently causes blood dilution of the specimen, which may result in loss of the few cells collected. Initially, we and other groups experienced a 15-20% inadequate sample rate. We have modified our technique to employ

multiple sampling with smaller needles and reduced aspiration pressures, and we now obtain adequate specimens in over 95% of cases. This eliminates the need for the more complicated and traumatic cutting needle biopsy.

Aspiration biopsy results in a definitive diagnosis for most thyroid nodules, and in the remainder it provides information which is helpful in planning additional tests and treatment (surgery, scan, blood tests, etc.). At the Henry Ford Hospital, <sup>2,3</sup> needle biopsy is used as the primary triage technique for thyroid nodules. Prior to the time that needle biopsy was used, only about 5-10% of thyroid nodules removed surgically were

carcinoma, and with pre-surgical biopsy the percentage of carcinomas in operated patients has risen to over 50%. Approximately 70-80% of patients with thyroid nodules are spared surgery by this technique.

It is still necessary to operate on some benign lesions with a "follicular adenoma" pattern, because in some cases these lesions cannot be adequately distinguished from well differentiated follicular carcinoma. Other forms of needle biopsy are similarly unable to distinguish these two lesions, and surgical excision with examination of the tumor capsule is necessary to clarify the issue in these cases. It should also be noted that ABC can be used for diagnosis in cases of thyroiditis and diffuse hyperplasia (Graves' disease) when this seems medically appropriate.

It seems clear that in experienced hands the reliable results obtained by ABC make it the method of choice for the initial investigation of thyroid masses. The overall cost savings of analyzing patients by initial ABC, instead of starting with a scan plus ultrasound, is about 60%.7 Complications, consisting of minor hematomas, occur in fewer than 5% of cases.

### Breast

As in the case of thyroid nodules, a breast mass is frequently benign, but carcinoma must be excluded. In mammography, 20% of benign lesions appear "suspicious." Despite advances in mammography and breast ultrasound, a tissue diagnosis is required before treatment in all malignant appearing lesions. ABC offers the ability to specifically define most masses. A false-negative rate from 7-25% has been reported.<sup>2,4,8,9</sup>

The variables affecting the quality of an ABC specimen in the breast include the normal fat, the desmoplastic response, and the accuracy of needle placement. Because fat is easily aspirated, it often dilutes breast samples. Fat decreases cellular adhesion to slides because it is soluble in the alcohol found in most stain preparations and fixatives. The desmoplasia (fibrosis) common to "scirrhous" breast cancer inhibits release

of the cancer cells. To overcome these problems we aspirate with a 22 gauge needle and smear on totally frosted slides. No air-dried smears are routinely made. A large breast may prevent adequate mass palpation; a radiologically guided approach is highly recommended in this case. A trained aspirator who can perform or analyze mammography and ultrasound examinations will more accurately place the needle in smaller lesions. Lesions over 3 cm are generally accurately guided by palpation alone.

Breast ABC analysis presents several problems. Most benign processes, including fibroadenoma, mastitis, lactating adenoma, and fibrocystic disease, have characteristic patterns. Frequently, however, fibrocystic disease is scantly cellular because of fibrosis. Malignant processes are easily diagnosed except in "scirrhous carcinoma," lobular carcinoma, and "bland" adenocarcinoma in the elderly patient. In "scirrhous carcinoma," reduced cellular yield may result in a "negative" or "suspicious but not diagnostic" result. Lobular carcinoma forms 5-10% of breast cancer and is difficult to diagnose because of its small cellular size and isolated cell pattern. About 25% of women over 65 years of age with ductal carcinoma will have cells minimally altered from normal. In this case a very cellular sample alerts the analyzer to the true nature of the lesion.

If a breast ABC is negative and adequately cellular in a lesion with slightly atypical radiologic changes, appropriate follow-up would include mammography with repeat sampling should the lesion change. However, any negative ABC result in a radiologically highly suspicious lesion necessitates repeat ABC or surgical biopsy. The reduction of false-negative cases at our institution in our latest figures is primarily the result of experienced procurement and processing. We have had excellent success evaluating material collected by a radiologist specializing in breast examination.

There is much concern about the early detection of breast cancer. In addition, there is a need to decrease unnecessary surgical excision of benign breast disease.

When ABC is used, specificity and sensitivity are increased at almost no risk (minor hematoma 5%). The patient who is accurately informed prior to hospitalization is likely to obtain timely treatment with the freedom to investigate options.

### Lymph Nodes and Other Palpable Masses

Palpable subcutaneous masses are frequently found in the head and neck-and occasionally in the trunk and extremities. Enlarged lymph nodes are most often the cause. Since a lymph node must enlarge many times to become palpable, the majority of the node is composed of the tissue representative of the pathology. This makes several aspiration samples very reliable in diagnostic evaluation.8 A blood-diluted sample is undesirable and can be avoided by gentle collection with 25 gauge needles. Smears must be made very gently because of the fragility of lymphoid cells. Air-dried smears are very helpful.

With experience, lymphoma is usually separated from reactive hyperplasia, but a few cases are equivocal (less than 5%). However, surgical biopsy is needed in the initial diagnosis of lymphoma to define "nodular" versus "diffuse" growth. Frequently, ABC is helpful in cell typing (i.e., "large cell" vs. "small cell," "cleaved" vs. "non-cleaved"). Hodgkins disease is easy to diagnose because of the extremely large size of Reed-Sternberg cells; however, its sub-typing also requires surgical biopsy. ABC can be used alone in staging or documenting recurrence in all lymphomas. Metastatic carcinoma is as easily diagnosed as in surgical biopsy. If the primary is not clinically apparent, special stains and electron microscopy can be performed.

Its specificity and sensitivity make ABC extremely valuable in the staging of virtually all malignancies involving lymph nodes. The low and high-risk patients' acceptance allow a physician to reliably define the cause for an "enlarged node" without the need for a "wait and see approach." This is particularly useful in the pediatric age group because of frequent reactive adenopathy.

A subcutaneous of dermal mass which

is not a lymph node can often be successfully diagnosed. However, very small cutaneous or dermal lesions are usually best excised because the diagnostic biopsy is usually therapeutic and costs are similar. Large epidermal cysts (so-called "sebaceous cysts") and lipomas are frequently diagnosed benign lesions. Basal cell carcinoma, squamous carcinoma, and melanoma are easily diagnosed. Fibrous lesions (reactive fibrosis or fibrous neoplasm) may be difficult to diagnose due to scant cellularity.

Salivary gland masses are relatively easy to sample except in occasional fibrous benign mixed tumors (pleomorphic adenoma). Sampling is often more painful than in other sites, probably because of the proximity of the 5th cranial nerve. Malignancy is not difficult to identify, but subclassification is frequently challenging. Fortunately, the surgical approach is not determined as much by the diagnosis as by clinical evidence of facial nerve involvement. However, ABC allows patient preparation, staging, and elective surgical scheduling for benign lesions.

Overall, ABC of the palpable masses discussed above is easily performed on an out-patient basis and without complication. The elimination of low yield nonspecific tests aids in cost containment. Referral to a specialist is made after a specific diagnosis is rendered, reducing delay and consultation costs. In a low-risk patient the cost: benefit ratio of ABC is much more acceptable than surgical biopsy, which eliminates the need for a "wait and see approach." If optimally utilized, ABC allows high detection at low cost with virtually no complication or suffering for the patient.

### Deep Thoracic and Abdominal Masses

Since most of these lesions are non-palpable, they are usually sampled with radiologic guidance. Rapid specimen analysis is used during the procurement to assure specimen adequacy and the inclusion of special studies. This virtually eliminates repeat procedures, increases definitive non-malignant diagnoses, and increases the efficiency of both the radiologist and cytopathologist.

Radiologically guided ABC in the

thorax is the only site where complications of the procedure are significant. Pneumothorax will occur in about 20% of patients, and about 5% require chest tube placement. By utilizing a Greene needle (outer guiding needle 19g-10 cm; inner sampling needle 23g-15 cm) and sterilized slides, multiple samples can be taken using only one puncture of the pleura. We can often sample 10 to 15 times without difficulty within 30 minutes. With experience, a nonmalignant peripheral lung nodule can be diagnosed with confidence in a majority of cases, precluding resection for fear of a false-negative result. Malignant lesions are definitively diagnosed 97% of the time with specific cell typing in 95%. Because of the high yield, low cost, and low complication rate, ABC will likely be used in place of bronchoscopy and mediastinoscopy in many patients. Outpatient lung aspiration is a safe procedure if proper post-procedure monitoring is provided.

Deep abdominal ABC is surprisingly safe; no significant complications are reported in transabdominal samplings with a 22 gauge needle in several large series.7,8,9,10 We have had the same experience. These small flexible needles are virtually self-sealing as they pass through bowel. Even the aorta or vena cava are not significantly damaged if accidentally penetrated. Computerized tomography allows guidance in most instances, with ultrasound being used in the pancreas, liver and kidney on occasion. Rapid smear analysis guides sampling attempts and specimen triage. This approach allows several needle re-positionings, usually resulting in a definitive diagnosis.

Primary or metastatic malignancies in the liver, gastrointestinal tract, pancreas, kidney, prostate, female genital tract, retroperitoneal lymph nodes, and adrenals are diagnosed in over 90% of cases. Therefore, exploratory laparotomy for diagnosis or staging is avoidable.

### Other Sites

A variety of other sites an be sampled. We have sampled transvaginally and transrectally for both uterine, pelvic wall and prostatic lesions. A special Franzen needle guide is utilized. Deep soft tissue

and bone are sampled by palpation or fluoroscopy. In Sweden, intracranial ABC via burr hole and stereotactic guidance is the method of diagnosis in over 95% of brain tumors. In all these sites, complications are almost non-existent in experienced hands.

Most of our female genital tract samples are procured by experienced gynecologists. Often only one or two samplings are obtained. The use of the long needle guide in the transvaginal or transrectal approach is expedient. However, this method makes sampling more difficult, explaining the higher inadequacy rate in these cases. If clinically suspicious, a negative initial ABC result prompts a repeat ABC by radiologic guidance.

#### Conclusion

The most definitive and reliable method of diagnosis in medicine is tissue biopsy. ABC has been proven to be a safe tissue biopsy method with sufficient reliability to be used as the initial test in most mass lesions. However, optimal reliability is highly dependent on procurement and preparation quality. If an experienced cytopathologist is available, the ABC consultation is an alternative to surgical biopsy and can be rapidly completed, often on an outpatient basis. When definitive information about a mass lesion is obtained initially, needless tests and hospitalization are eliminated. This information has a psychological advantage by relieving the patient's anxiety in benign processes and allowing prompt intelligent pursuit of treatment options in malignancy. Staging of malignancy is simplified and safe with ABC. When recurrence of malignancy is documented by ABC, the lack of a healing phase allows immediate chemotherapy or radiation therapy.

Recent needs for cost control in medicine make ABC highly attractive. The total cost per biopsy is only 20-30% of that for surgical biopsy, and ABC has virtually no anesthetic risk or surgical trauma. Patient acceptance is very high, even when surgical biopsy has been refused.

In the near future, as trained person-

nel become available, outpatient ABC consultative clinics will be feasible. A primary care physician would be able to routinely refer patients with mass lesions for ABC diagnosis as the initial test. In about 90% of cases the ABC diagnosis would allow the patient's treatment, staging, or follow-up with little or no hospitalization. In the remaining 10% of cases, the ABC diagnosis would efficiently guide the diagnostic workup which could include repeat ABC, surgical biopsy, or other tests. Since hospitalization is the major cost in patients with mass lesions, a significant cost reduction would be realized. With this scenerio in mind, it seems that ABC is destined to become the "Biopsy Technique of the Eighties."

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## **Current Status of Bariatric Surgery**

J. E. ARATA, M.D. ALLAN J. PERRY, M.D. Fort Wayne

Morbidly obese patients who seek significant weight reduction have but one recourse—surgery. We think the trend toward gastroplasty will increase . . .

ORBID OBESITY is a common malady affecting approximately 6% of the adult population of the United States. A person is considered to be morbidly obese if he satisfies any of the following criteria: 1) he is at least 50% over his ideal body weight, 2) he is double his body weight, or 3) 100 pounds over his ideal weight. There are various "body weight charts," but a rule of thumb for ideal weight for a female of 5 feet is 100 pounds. One should add five pounds for each inch added to her height. Ideal weight for men is 10 to 15 pounds greater than for women of equal height.

According to Martin E. Felder, M.D., the classical indications for obesity surgery should be re-defined. He presented a series of patients who were operated upon in spite of the fact they did not fall within the usually recommended indications. He emphasized those who were less than 100 pounds above their weight. Included among his patients were those who had marked pulmonary problems, severe cardiac disorders, intractable diabetes mellitus, and a variety of orthopedic problems. His results disclosed a satisfactory weight loss with marked improvement of the concomitant medical disorders. His postoperative morbidity was essentially unchanged from that same in heavier patients.'

Morbid conditions, common in extremely obese people, increase with the length of time the obesity has been present. It is estimated that people have one chance in seven of living a normal life span if the obesity persists to this degree. Among the common morbid conditions are Type II diabetes, hypertension, coronary artery disease and arteriosclerosis, pulmonary insufficiency, osteoarthritis of the knees, ankles, hips, spine, and a poor personal image. Most of the symptoms related to the above pathology will be lessened with dramatic weight loss. It is very common for Type II diabetics to be

able to discontinue use of insulin when their weight falls, either due to dieting or following successful bariatric surgery. Symptoms of osteoarthritis are markedly diminished with a loss of 40% of the excess weight. Shortness of breath disappears with less weight loss. Amelioration of hypertension is less predictable.

Although there is much wishful thinking regarding the advantages of dietary therapy in obesity of this magnitude, dietary therapy is probably less than 1% effective. Even though the symptoms are due to overeating, such patients have poor compliance with dieting and following appropriate instructions; when they are criticized for failure, nothing of a positive nature is accomplished. If they are "out of sight," they are "out of mind." Nonoperative therapy for morbid obesity, thus, is virtually worthless.

Morbidly obese patients who seek significant weight reduction have, unfortunately, but one recourse—surgery. Other common modalities including dietary therapy, anorectic medications, group therapy (Weight Watchers, TOPS, Slim and Trim, Overeaters Anonymous), and other imaginative methods including the application of staples to the ear, acupuncture, and jaw wiring have been tried without appreciable success. Most of the patients seeking operative therapy have tried a selection of the above and are monuments to the futility of these efforts.

### Psychological Makeup of Morbidly Obese Patients

Adequate studies show that such patients are not suffering from major psychological problems. Dr. Lantz,² and others, have written on this, and the only common finding in such patients was an "alcoholic personality." They, personally, tested over 400 of our morbidly obese patients and compared this group to a similar group from the Indiana Univer-

Correspondence: 3301 Lake Ave., Fort Wayne, Ind. 46805.

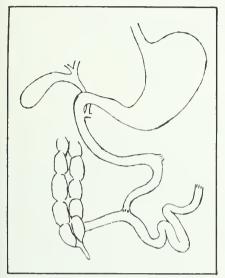


FIGURE 1A: Jejunoileal bypass, end-to-side.

sity Medical Center. There were no common psychological differences between the patients in our private practice who have been subjected to surgery and those who had been subjected to surgery at the Medical Center. Attempts at psychotherapy with such patients had not met with any appreciable success.

Other studies on the etiology of obesity have elucidated the difference in fat cell size, the number of fat cells, and other metabolic considerations, but the bottom line indicates an intake of calories greater than the usage of calories with subsequent fat storage. This has led surgeons to devise operations to limit the intake of calories.

Surgical attempts for the control of obesity may be classified as:

- 1. Attempts to prevent the absorption of food
- **2.** Attempts to prevent the intake of food
- 3. Combinations of No. 1 and No. 2 Jejunoileal bypass (*Fig. 1*) was the first procedure to gain any popularity. This operation proved to be successful in reducing the excess weight but was followed, after a variable period of time, with symptoms and findings which necessitated the reversal of the operation in approximately 50% of the patients. Among the unfortunate sequelae were an arthri-

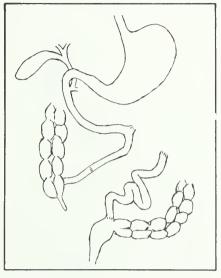


FIGURE 1B: Jejunoileal bypass, end-to-end.

tic-like syndrome, intractable diarrhea, gas bloat syndrome, hemorrhoids and anal fissures, an occasional intussusception of the bypassed intestine, development of anemia, weakness, cirrhosis of the liver from protein malnutrition, development of renal calculi and biliary calculi, and evidence of a decrease in the immune reaction.

Between 1968 and 1978, we carried out 285 such operations with only one hospital mortality. We used the 12-6 inch, end-to-side jejunoileo bypass in continuity. When it was mandatory, we were able

to reverse these operations safely. Intravenous hyperalimentation in severely depleted patients was necessary prior to surgery. If the operation was reversed, however, and another operation was not carried out concomitantly to prevent weight gain, these individuals invariably regained and often exceeded their initial weight. A number of surgeons still use the operation including Payne,<sup>3</sup> and variations of the operation are carried out by Scopianaro<sup>4</sup> and Holian.<sup>5</sup> In general, the operation has been replaced by gastric operations.

In 1966, gastric bypass (Fig. 2) was proposed for the control of extreme obesity. It was frequently noted that a high-gastric resection, commonly employed in the treatment of duodenal ulcers or carcinoma of the stomach, was frequently followed by permanent weight loss. This was considered an adverse effect; but when a high-gastric resection was applied to a very obese patient, this proved to be a beneficial effect. Thus, the idea of a high-gastric resection was modified, and gastric bypass was devised.

Gastric bypass was followed with fewer untowards sequelae than the jejunoileo bypass, but the initial operative risk was greater, and a number of the people regained a significant portion of their weight because the residual pouch dilated as did the stoma of the gastrojejunostomy. Further studies on gastric bypass

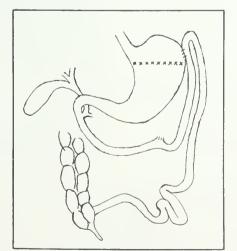


FIGURE 2A: Gastric bypass.

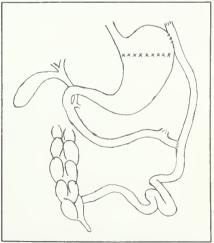


FIGURE 2B: Gastric bypass, rou-en Y.

pointed to occasional vitamin deficiencies, iron deficiencies, and a failure rate which was troublesome. This operation is still a very popular operation and shares the stage of bariatric surgery with gastroplasty. In a survey in 1983 carried out at the Bariatric Surgery Colloquium, 112 surgeons were using gastroplasty in some form while 37 surgeons attending this meeting were using a gastric bypass. \*

The search for safer, more effective measures continued, and gastroplasty as a means of weight control in the morbidly obese patient was instituted. Essentially, gastroplasty limits the intake of food by the creation of a small gastric pouch, and the emptying of the small pouch is delayed by limiting the size of the efferent stoma. Operative mortality and morbidity is less, and vitamin and mineral deficiencies seem inconsequential.

Other attempts to limit the intake of food include the gastric wrap of Dr. Wilkinson.<sup>9</sup> The stomach volume is decreased by an envelope of non-absorbable Prolene mesh (Fig. 3).

In 1978, Pace, Carey, and Martin at Ohio State University popularized transverse gastroplasty with midline staple stomas (*Fig. 4a*).<sup>10</sup>

Others used stomata on the greater curvature (Gomez, et al., 11 Fig. 4b). Transverse stapling with midline stomas or stomas on the greater curvature have been largely relegated to history because of frequent vomiting due to stenosis or dilatation of the small fundal pouch, and dilatation of the stoma with loss of effectiveness of the operation. It became apparent to all workers in the field that non-absorbable material was necessary to

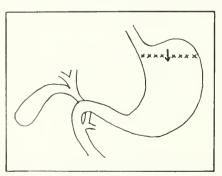


FIGURE 4A: Gastroplasty (Pace).

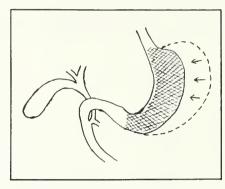


FIGURE 3: Gastric wrapping (Wilkinson).

reinforce the efferent stoma to prevent dilatation. These attempts were plagued with intrusion of the material into the gastric lumen. Such intrusions frequently necessitated the removal of the material via endoscopic methods or open surgical methods.

Our success rate with transverse gastroplasty never exceeded 40% despite the use of extra rows of staples and extra reinforcement. Our results are similar to other published series. The 40% success is 40 times better than medical therapy, but the 60% that are failures are a great disappointment to those patients who have had surgery which has been non-effective.

On occasion, surgeons unfamiliar with this type of surgery with the use of non-absorptive materials to reinforce the stoma, would solve the problem of mesh intrusion by removing the distal portion of the stomach. The subsequent gastrojejunostomy was attended with a decent chance of maintaining ideal weight, and the results were parallel to those of gastric bypass. Other complications of the

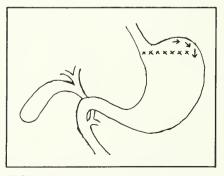


FIGURE 4B: Gastroplasty (Gomez).

transverse gastroplasty were the occasional development of gastric ulceration and vomiting due to stomal obstruction. If the vagi were injured during the course of the gastroplasty, delayed emptying of the distal pouch was a troublesome problem.

Vertical banded gastroplasty was first introduced by Tretbar.12 A vertical pouch along the lesser curvature would empty better and dilate less because of the tough vagus nerve fibers surrounding the pouch and the thickness of the stomach along the lesser curvature. To prevent dilatation of the efferent stoma, various prostheses were used to surround the outlet of the vertical pouch. The most successful ones include the use of Silastic tubing held in place along the distal stoma with a suture of Prolene through the Silastic tubing,13 and the method of Dr. Mason14 who uses a Marlex collar about the stoma. To prevent the intrusion of the foreign material of the stoma, a button hole was made, and the collar was not attached to the stomach wall but merely surrounded the outlet of the pouch. The reported incidence of intrusion of tubing or plastic material into the lumen of the stomach is very low, probably because such appliances are not attached to the stomach by suture but merely surround the stoma.

The vertical banded gastroplasty of Mason was first instituted in 1980 and has gained a greater and greater acceptance and now is more popular than gastric bypass (Fig. 5); 90% of surgeons performing gastroplasty are using a vertical pouch. The mortality is less than 1%, the efficacy is over 80% at one year, and the re-operative rate at one year is less than 5%.

Since employing this operation for the past two and one-half years, we have had almost no trouble with early obstruction and early or late failure of the procedure. We are enthusiastic about this. We do not know what the long-term incidence of mesh intrusion will be, but generally, if one has problems with a gastroplasty operation, these problems tend to manifest themselves in the first year.

At present, we think the trend of bariatric surgery toward gastroplasty will

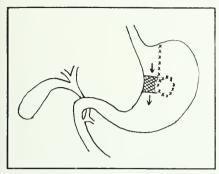


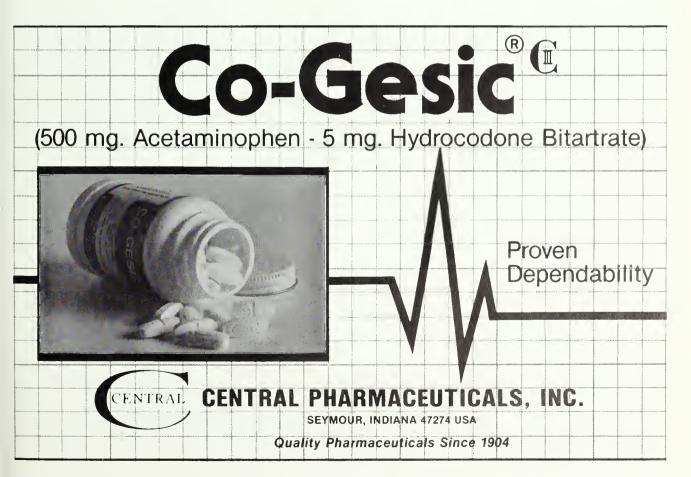
FIGURE 5: Banded vertical gastroplasty (Mason).

increase, and gastric bypass will probably be performed less often because of the lower mortality of gastroplasty, the absence of mineral and vitamin deficiencies, and the relatively high success rate.

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### **Diet and Cancer**

JAMES Y. McCULLOUGH, M.D. New Albany

URING MY MEDICAL SCHOOL days, 50 years ago, carcinoma of the scrotum in chimney sweeps was recognized to be due to an external agent, coal tar.

Fifty years ago cancer of the stomach was the most common cancer in men. Carcinoma of the lung was exceedingly rare. Now carcinoma of the stomach is uncommon and cancer of the respiratory tract is the most common cancer in the male and is overcoming cancer of the breast. The explanation suggests an exogenous reason and the obvious one in the case of cancer of the stomach is that years ago lard was the principal seasoner and the housewife heated the same lard over again and again. Every farm had a smokehouse and the pork was preserved by salting and hung in the smokehouse. Now these are oddities. Lard has been replaced by vegetable oil and the industry is breeding beef and hogs with less fat. The incidence of gastric cancer has decreased strikingly.

Cigarettes used by few 50 years ago have now become the agent greater than all others as a cause of cancer.

The author has compiled this article based on excerpts from a 1983 symposium presented in Boston by the Cancer Committee of the New England Deaconess Hospital under the auspices of the Dept. of Continuing Education, Harvard Medical School. The author, a diplomate of the American Board of Surgery, has included his own professional observations.

Correspondence: 700 E. Spring St., New Albany, Ind. 47150.

### Dietary Fiber and Transit Time

A British epidemiologist, Burkitt (of Burkitt sarcoma), working in Africa found almost no diverticulosis or cancer of the colon in the blacks in the bush. They were patients in hospitals in the interior of Africa, hospitals staffed by capable doctors educated in Belgium and England and quite capable of diagnosis of these ailments. Burkitt further observed that the black man emigrated to

the coastal cities and adopted the food of the affluent Western world. He then developed the carcinoma and diverticulosis of the people in the area to which he migrated. Burkitt attributed this difference to the ingestion of fiber in the poor populations, and the decrease in transit time of the fiber through the bowel.

Although the mode of operation may not be in fact correct, these changes are

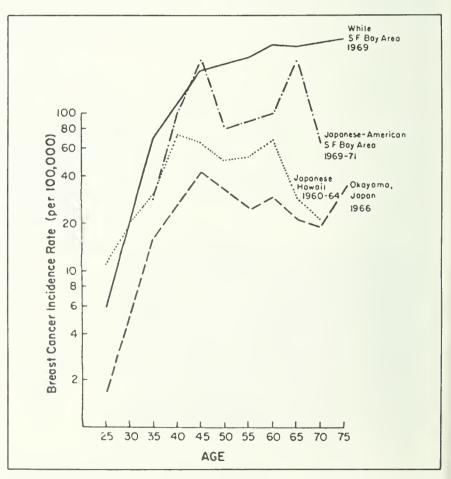


FIGURE 1: The annual incidence of breast cancer plotted with age for Japanese living in Japan (1966), Japanese-Americans in Hawaii (1960-1964), and in the San Francisco Bay area (1969-1971).—Buell P: Journal of the National Cancer Institute. 51:1479, 1973. Reprinted with permission.

indisputable evidence that cancer is related to external environmental effects.

Approximately 20% of all deaths in the United States are caused by cancer and, although the number of cancer cases is steadily increasing as the population grows, the age-adjusted total cancer incidence and mortality rates for sites excluding the respiratory tract have, as a whole, remained stable during the last 30 or 40 years. Cancer of the respiratory tract accounts for 25% of all cancer deaths and cigarettes are considered to be the cause.

The search for cause of cancer has, for the most part, concentrated on the genetic influence and to a lesser degree on environmental factors. Increasing studies have made it clear that cancers have external causes and, in principle therefore, should be preventable. For example, Blacks and Japanese residing in the United States developed the spectrum of cancers that is typical for the United States but different from that in Africa and Japan and different from the Japanese living in Japan and from those living in San Francisco (Figure 1).

Epidemiologists have found it relatively easy to demonstrate a correlation between diets consumed in modern "affluent" societies and the incidence of cancer in such organs as the breast, colon and uterus (Figure 2).

### **Environmental Factors**

Many factors in our environment are potential causes of cancer. They include substances in the air, the water we drink and the regions in which we work and live and the food we eat. The association between diet and cancer has focused on cancer of the GI tract, the breast and other tissues susceptible to hormonal influence, and to a lesser extent the respiratory tract and urinary bladder, endometrium and prostate. Figure 3 shows the relationship between endometrial cancer mortality rate and per capita dietary fat consumption for 16 countries. The implication from these and other data is that low fat, high fiber diet would reduce the risks of endometrial, breast and colonic cancer.

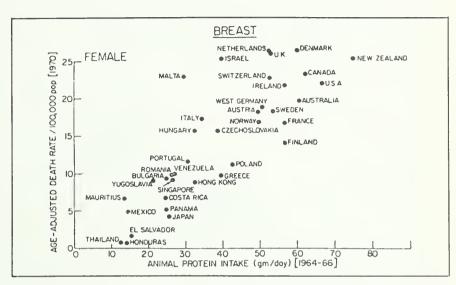


FIGURE 2: Correlation between breast cancer mortality rates and per capita daily animal protein consumption for different countries.—Carroll KK: In Nutrition and Cancer, p. 25, Wiley-Interscience, New York, 1977, Reprinted with permission.

The likelihood that some of these correlations reflect cause is strengthened by laboratory evidence that similar dietary patterns and components of food also affect incidence of certain cancers in animals.

### Dietary Fat

Studies have repeatedly shown an association between dietary fat and occurrence of cancers at several sites. especially the breast, prostate and colon. Mortality from breast cancer has been shown to correlate strongly with a higher per capita fat consumption. The few casecontrolled studies conducted have shown this association with dietary fat. Like breast cancer (Figure 4), increased risk of large bowel cancer has been associated with higher fat intake in correlation with case-controlled studies. The data on prostate cancer are more limited but they too suggest an increased risk is related to high levels of dietary fat.

Like the epidemiological studies, numerous experiments in animals have shown that dietary lipids influence tumorigenesis, especially in the breast and in the colon. An increase in fat intake from 5% to 20% of the weight of the diet—that is, approximately 10% to 40%

of total calories—increases tumor incidence in various tissues. Conversely, animals consuming low fat diets have a lower tumor incidence.

Some studies suggest that the development of colon cancer is enhanced by the increased secretion of certain bile steroids and bile acids that accompany high levels of fat intake. Nonetheless, there is little or no knowledge concerning the specific mechanisms involved in tumor promotion.

Data on cholesterol and cancer risks from studies in animals are too limited to permit any inferences to be drawn. Many studies of serum cholesterol levels and cancer mortality in human populations have demonstrated an inverse correlation with colon cancer among men but the evidence is not conclusive. Low cholesterol may be an effect rather than a cause.

### **Protein**

The results of epidemiological studies based on protein intake and carcinogenesis suggest possible association between high intake of dietary protein and increased risk of cancer. Although the literature on protein is much more limited than the literature concerning fats

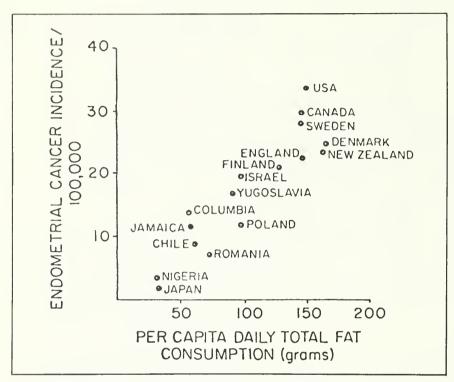


FIGURE 3: Relationship between endometrial cancer mortality rate and per capita daily total fat consumption for 23 countries.—Armstrong B, Doll R: International Journal of Cancer, 15:617, 1975. Reprinted with permission.

and cancer, and because of the very high correlation between fat and protein in the diet of most Western countries, and because the more consistent and often stronger association of these cancers with fat, it seems likely that dietary fat is the more active component. Experimentally induced carcinogenesis appears to be enhanced as protein intake is increased.

### Alcohol

There is limited evidence that excessive alcohol consumption causes hepatic injury and cirrhosis which in turn may lead to the formation of hepatomas. When consumed in large quantities alcoholic beverages appear to act synergistically with cigarette smoking.

Several studies in the United States found that among heavy drinkers of alcoholic beverages whiskey was the most important factor for head and neck cancer. For cancer of the esophagus the risk of a heavy whiskey drinker, drinking over 6 ozs. daily, was 25 times the

risk of a nondrinker while the risk of a heavy beer drinker, drinking over 48 ozs. daily, was 10 times the risk of a nondrinker when controlled for tobacco.

Among 200 patients with cancer of the head and neck, a study revealed that 11 persons had abstained from all alcoholic beverages and tobacco and all but one of the 11 patients had used mouthwash several times daily for more than 20 years. Most commercially available mouthwashes have an alcoholic content of 14% to 28%. There is an undeniable synergistic effect of the interaction of alcohol and tobacco.

### Carcinogens

There are local effects due to direct contact through carcinogens in the alcoholic beverages or by the action of alcohol as a solvent for tobacco carcinogens.

Carcinogens are found in nutrients that are natural constituents of foods, metabolytes and mycotoxins such as car-

cinogen aflatoxin and of bacteria and carcinogenic nitrosamines, some of which are contaminants whereas others are normal components of common foods.

### Mutagens

Mutagens are substances that cause inheritable changes in the genetic material of cells. If a chemical is mutagenic to bacteria or other organisms it is generally recorded as a suspect carcinogen, although carcinogenicity must be confirmed in long-term tests in whole animals. Mutagens in charred meat and fish are produced during the cooking of proteins at high temperatures. Smoking of foods as well as charcoal broiling results in the deposition of mutagenic and carcinogenic polynuclear organic compounds. It is not yet possible to assess whether such mutagens are likely to contribute significantly to the incidence of cancer.

Pickled salt-cured spicy foods are often associated with formations of nitrosamines in foods, and nitrosamines are carcinogenic and their consumption by populations that have high incidence of stomach cancer suggests that conditions which promote the formation of nitrosamines increases the risk of cancer of the stomach. While this has not been established in human populations, it is clearly the case in experimental animals.

### Nitrites and the Role of Antioxidants

In the United States nearly 3,000 substances are added to the food intentionally during processing or unintentionally in the packaging material. Of the few direct food additives that have been tested and found to be carcinogenic in animals all except saccharin has been banned from use in the food supply.

Some parts of the world, especially China, Japan and Iceland, where there are populations that frequently consume salt-cured or smoked foods, show a greater incidence of cancer at some sites, especially the esophagus and stomach.

There are certain sects of the American population which subsist on diets somewhat different from the major population. These include the Seventh Day

Adventists and the Mormons as well as vegetarians with no religious persuasion. These members of our population are known to have diminished incidence of cancer as compared to the general population of the United States.

From the data derived from such studies, it appears that there has been a decrease in stomach cancer and accompanying increase in colon tumors in different populations after their adoption of the food habits of the Western world. Thus, the lifestyle and food habits may involve more than one target organ.

There is also evidence to suggest that the consumption of certain foods, particularly certain vegetables, especially the carotene rich, such as dark green and deep yellow vegetables and cruciferous vegetables such as cabbage, broccoli, cauliflower and Brussels sprouts is associated with reduction in the incidence of cancer in animals.

Antioxidant nutrients and synthetic food additives as well as other antioxidant compounds are anticarcinogenic in laboratory animals. Several antioxidant compounds have been shown to inhibit chemical induction of tumors of the skin, mammary gland, gastrointestinal tract, liver and lung.

### Vitamins

Vitamins A, C and E and selenium have been studied for anticarcinogenic activity in animals and to a limited extent in patients. These two vitamins and minerals have shown activity in blocking formation of carcinogenic nitrosamines and have given evidence of blocking tumor induction by other chemicals.

Much has been written in recent years about the value of ascorbic acid in disease prevention. It is the clinical reports, however, that have captured the attention of the lay public. Dr. Linus Pauling is probably the best known for his writing and discussions on the nature, causes, prevention and treatment of cancer with special reference to the value of vitamin C. There is emerging evidence now that ascorbic acid may indeed be effective in the context of a more complete diet in preventing some forms of cancer. Cer-

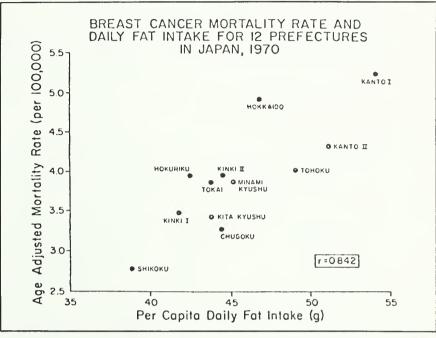


FIGURE 4: Correlation between age-adjusted breast cancer mortality rate and daily fat intake in 12 districts of Japan.—Hirayama T: Preventive Medicine, 7:173, 1978. Reprinted with permission.

tainly, one cannot doubt the real or potential value of ascorbic acid as a scavenger in diets to prevent the nitrosation of amines which are in themselves highly carcinogenic to animal species.

Ascorbic acid inhibits the formation of nitrosamines. This appears to be a result of reacting with nitrite and thus preventing reaction with amines in the diet.

Vitamin E suppresses growth of transplanted tumor in mice and reduces induction of chromosome abnormalities by benzopyrene *in vitro*. Both vitamins decrease fecal mutagen content in human subjects. Vitamin C prevents or reverses chemical transformation of cells *in vitro*.

In vitro vitamin E protects cell membranes from oxidation degradation due to selenium deficiency, presumably because of its own antioxidant capacity.

Selenium has been found to decrease mutagenic activity of a variety of known carcinogens. In tissue culture selenium reduces the metabolic activity of certain carcinogens, altering the patterns of degradation to favor less toxic metabolytes. Selenium also plays a key

role in the activity of glutathione peroxidase, an enzyme that protects tissue against oxidative damage.

Vitamin E is present in a wide variety of natural foods including vegetable oils, eggs, whole grains and many of the cereals. The primary form of vitamin E is alpha tocopherol, a form that has been associated with beneficial influences on cancer in experimental animal models.

Investigators have observed that mice with pyrene-induced sarcomas had an increased survival if they were given alpha tocopherol.

Haber and Whistler noted a marked decrease in carcinogenicity of methyl-cholanthrene in mice if the animals were given diets containing supplemental vitamin E. There appears to be more evidence for than against a protective effect for vitamin E with several carcinogen-induced tumors in animals.

As with ascorbic acid it has been amply demonstrated that vitamin E is an effective blocking agent in nitrosation, and this confirms its potential role as a protective agent in the environment.

An additional trace element that has been recently associated with risk of cancer is zinc. It has been clearly established that heavy drinkers or smokers are at greater risk for esophageal cancer. These individuals have low tissue levels of zinc and other trace elements as well as decreased levels of vitamins. Zinc tissue concentrations are low in patients with a number of other types of cancer but esophageal cancer patients record the lowest tissue zinc levels. These observations have been confirmed in animal studies. Therefore, it appears that a number of vitamins and minerals are involved in susceptibility to certain forms of cancer.

### Dietary Manipulation

The most intriguing conclusion in terms of cancer prevention is that, although cancer is a leading cause of death in the United States today, dietary factors may be implicated in approximately 35% of all cancer deaths and thus through dietary manipulation a large portion of cancers may be preventable.

This optimism derives from observations of the differing international cancer mortality rates as well as migrant studies which have usually found the cancer rates of migrants approach those of the host population within two or three generations.

One of the nutritional factors which appears most promising as an antineoplastic agent is vitamin A, either as retinol (preformed vitamin A), derived from animal sources, or beta carotene (provitamin A), derived from vegetable sources.

One proposed retinol-related

mechanism which has been tested in animals is that of retinoids; chemical analogues of retinol somehow prevent already altered or damaged cells from developing into actual malignancies. Retinoids appear to block the process of carcinogenesis during the latency period and act to prevent the final progression of altered cells into truly neoplastic clones. Some clinical trials suggest that retinoids also may have protective effects against carcinogenesis in humans.

A second hypothesized mechanism relates primarily to beta carotene. Carotene could break the chain of events leading to the development of cancer by preventing cellular damage from highly reactive molecules. Although this hypothesis is not yet supported by laboratory research, epidemiologic studies conducted in various parts of the world generally find a significantly lower risk associated with higher intake of vegetables high in beta carotene. However, although investigators have assumed that beta

carotene content of the vegetables accounts for the decrease in cancer risks, the other constituents of vegetables such as dietary fiber or some non-nutritional factor relative to the vegetable intake may be the true determinent.

#### Harvard Studies Beta Carotene

A group in the Harvard faculty is currently conducting the Physicians Health Study, a randomized placebo-controlled trial of aspirin in the prevention of cardiovascular disease and beta carotene in the prevention of cancer.

This study will examine the effect of taking a 15 mgm. capsule of beta carotene every day on total cancer incidence among over 20,000 male U.S. physicians. Baseline blood studies can be analyzed for carotene, retinol and retinol-binding protein levels. Consequently, this trial should allow us to determine with a fair degree of certainty whether carotene itself has a protective effect and which sub-groups, if any, stand to benefit most.

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### **Precocious Puberty Due to a Diaper Ointment**

C. E. HEALY, M.D. Evansville

The onset of secondary sexual changes in a young child is a serious problem, both psychologically for the parents, and medically for the physician; and its occurrence usually triggers a rather extensive workup. We recently studied a female infant with both breast and pubic hair development, which we suspect was due to an ointment used in the diaper area.

### Case Report

The patient is an 8.5-month-old girl who was born after a normal pregnancy and delivery and who was normal at birth. However, instead of the normal breast budding of the newborn resolving, the breasts continued to gradually increase in size. At about 8 months of age the mother noted the beginning development of coarse, dark pubic hair. The ex-

Correspondence: 421 Chestnut St., Evansville, Ind. 47713.

amination revealed a normal appearing 8-month-old child with height at the 90th percentile and weight at the 50th percentile. The breasts were equal and enlarged to two centimeters. The tissue felt firm and attached to the slightly darkened areola. There were several strands of coarse, dark pubic hair on the mons pubis, but no labial or clitorial abnormalities.

### Laboratory Data

Bone age, skull, and abdominal x-rays were normal. T4, estridiol, 17-hydro-xyprogesterone, luteinizing hormone, and follicule stimulating hormone were all normal. Chemical analysis of Phillip's Corona Ointment, a veterinary salve, revealed the level of estridiol immunoassay reacting compound was 190 pg/gm of ointment. Mercury levels were not assayed.

### Discussion

Phillip's Corona Ointment is commonly used by mothers for prophylaxis against, and treatment of diaper rash. The compound contains several ingredients,

but the main one is an organic mercury compound in a bee's wax base. The bee's wax is probably the source of the estrogen. The coating effect of the wax and the biotoxic effect of the organic mercury are probably the reasons the compound is effective.

Even though the level of estridiol is low, the cumulative effect of the several times a day application to the infant's skin plus the occlusive effect of the wax base would tend to promote absorption. The oral administration of 150 ug of estrogen in 8- and 10-year-old children has been associated with the onset of puberty, so it appears likely that the dose is adequate to cause changes in an 8-month-old infant.

The amount of mercury absorbed might possibly be a problem, but a 24-hour urine mercury was not measured on this infant. She had no signs of heavy metal toxicity.

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is drug is not indicated for initial therapy of edema or pertension. Edema or hypertension requires therapy ated to the individual. If this combination represents the sage so determined, its use may be more convenient in tient management. Treatment of hypertension and edema. not static, but must be reevaluated as conditions in each tient warrant

traindications: Concomitant use with other potassium-ng agents such as spironolactone or amiloride. Further use unia, progressive renal or hepatic dysfunction, hyperkalemia existing elevated serum potassium. Hypersensitivity to either ponent or other sulfonamide-derived drugs.

existing elevated serum potassium. Hypersensitivity to eitner ponent or other sulfonamide-derived drugs.

ings: Do not use potassium supplements, dietary or otheratings: Do not use potassium supplementary potassium is markedly impaired. If supplementary potassium sied, potassium tablets should not be used. Hyperkalemia occupiant, and has been associated with cardiac irregularities. It broe likely in the severely iii, with urine volume less than one day, the elderly and diabetics with suspected or confirmed insufficiency Periodically, serum K\* levels should be deterd. If hyperkalemia develops, substitute a thiazide alone, of K\* intake. Associated widened QRS complex or arrhythrequires prompt additional therapy. Thiazides cross the stall barrier and appear in cord blood. Use in pregnancy res weighing anticipated benefits against possible hazards, ding fetal or neonatal jaundice, thrombocytopenia, other rise reactions seen in adults. Thiazides appear and trivene may appear in breast milk. If their use is essential, the nt should stop nursing. Adequate information on use in ren is not available. Sensitivity reactions may occur in ints with or without a history of allergy or bronchial asthma, tible exacerbation or activation of systemic lupus erythesus has been reported with thiazide diuretics.

nts with or without a history of allergy or bronchial asthmable exacerbation or activation of systemic lupus erythesius has been reported with thiazide diuretics.

autions: Do periodic serum electrolyte determinations (parrity important in patients vomiting excessively or receiving ateral fluids, and during concurrent use with amphotericin Bioticosteroids or corticotropin (ACTHI). Penodic BUN and in creatinine determinations should be made, especially in derly, diabetics or those with suspected or confirmed renal ficiency. Cumulative effects of the drug may develop in ints with impaired renal function. Thiazides should be used caution in patients with impaired hepatic function. They can pitate coma in patients with severe liver disease. Observe arily for possible blood dyscrasias, liver damage, other idionatic reactions. Blood dyscrasias have been reported in ints receiving triamterene, and leukopenia, thrombocyto-a, agranulocytosis, and aplastic and hemolytic anemia have reported with thiazides. Thiazides may cause manifestation and tabetes mellitus. The effects of oral anticoagulants may acreased when used concurrently with hydrochlorothiazide, ge adjustments may be necessary. Clinically insignificant sitions in arterial responsiveness to norepinephrine have reported. Thiazides have also been shown to increase the surrame. Triamterene is a weak folic acid antagonist. Do dic blood studies in cirrhotics with splenomegaly. Anti-rensive effects may be enhanced in post-sympathectomy instructions in arterial responsiveness of norepinephrine have reported in patients with histories of stone formation. A few occurse of acute renal failure have been reported in patients on idea when treated with indomethacin. Therefore, caution is found in renal stones in association with the other usual lius components. Therefore, Dyazide' should be used without in patients with histories of stone formation. A few occurse of acute renal failure have been reported in patients on idea when treated with indomethacin. Therefore, caution

rides may add to or potentiate the action of other antihyper-ve drugs.

etics reduce renal clearance of lithium and increase the risk

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num toxicity.

wise Reactions: Muscle cramps, weakness, dizziness, headdry mouth, anaphylaxis, rash, urlicaria, photosensitivity,
ura, other dermatological conditions, nausea and vomiting,
hea, constipation, other gastrointestinal disturbances, poshypotension (may be aggravated by alcohol, barbiturates,
arcotics). Necrotizing vasculitis, paresthesias, icterus,
reatitis, xanthopsia and respiratory distress including pneutiss and pulmonary edema, transient blurred vision, sialadeand vertigo have occurred with thiazides alone. Triamterene
peen found in renal stones in association with other usual
fulse components. Rare incidents of acute interstitial nephritis
been reported. Impotence has been reported in a few
nls on 'Dyazide', although a causal relationship has not
restablished.

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# **Experimental Medical Devices, Drugs and Techniques**

### Their Future Social, Medical and Political Implications (Part 3)

OTIS R. BOWEN, M.D.\* Indianapolis

EDICAL MALPRACTICE, in spite of statements that it is of recent origin, is not recent. The Code of Hummurabi back in 2200 B.C. contained a section recommending punishment for malpractice. The landmark case for establishing the doctrine of due care and diligence probably was when a decision was recorded in 1374 in England against a physician.<sup>16</sup>

A prominent malpractice defense lawyer, the late Claude M. Spilman, Jr., of the Bingham, Summers, Welsh and Spilman Firm of Indianapolis, Indiana who had participated with his partners in most of the serious malpractice suits within a 50 to 75 mile radius of Indianapolis over the past 25 years, said that health care had changed dramatically during that period. He said, "The sentimental picture of the family doctor sitting quietly by the bedside of the dying girl is truly a thing of the past. Today, she

would be in the hospital, perhaps in a big medical center, under the care of four or five specialists, with millions of dollars worth of machinery and equipment supporting her diagnosis and care. Yesterday, she probably died. Today, she almost always lives, recovers and goes home healthy in a very short period of time."

But public attitudes are also different. Reluctance to sue the old country doctor who's been a friend and neighbor is gone. The attorney said, "If the expected miracle (uneventful, total recovery) does not occur, too often a lawsuit follows." The assumption is that the hospital and/or the doctor are not only rich but well insured. Besides, the doctors were strangers and didn't have the caring attitude of the old country doctor."

The attorney said, "Few people really understand that malpractice is not merely another name for a professional mistake . . ." Stated more simply, "Malpractice is negligence, i.e., a failure to exercise reasonable care and skill. No health care provider . . . is guilty of malpractice or responsible to pay damages merely because of an error in judgment or because there was less than a perfect result."

It is unfortunate but the public tends to equate a bad result with bad practice and thus are more and more willing to sue. It is more unfortunate that some attorneys "automatically file suit with no investigation, no evidence of negligence, merely to see if they can get a nuisance-value settlement." These types of cases raise the cost of health care to everybody and raises the cost of new devices and

medicines to the ultimate recipients.

Some lessons from this are that the salesman or producer of a product, and the doctor as a user of the product, cannot make guarantees of cures or miraculous results. Even with modern-day miracles in medicine, not everyone has a happy result.

Remember, mechanical and chemical flaws can exist in a 60-inch coiled guide wire for it contains 64 feet of wire with much of its surface concealed inside the coils. When the manufacturer's label on the guide wire's box says, "Sterilize by autoclave or gas. Use once and discard," then the burden of the method of sterilization or for reuse rests on the user, and I suspect the legal implications would be great. "Patient safety comes about as a result of close cooperation between users and makers."

But if you think malpractice possibilities are great now, let's look to some dreams of the future. Here's a statement from Dr. Richard Jed Wyatt of the National Institute of Health: "You can't replace the brain. But that's our job—to learn to do that." A brain transplant should more truthfully be called a body transplant because the brain would contain the donor's personality and not the recipient's.<sup>18</sup>

But maybe Wyatt's remark isn't so farfetched for he and his group have transplanted important brain cells—bits of new brain tissue into animal brains to try to correct some of the disorders that affect human brains.

Dr. Erik Olaf Bochlund, a Swedish neurosurgeon, has transplanted cells into a patient with Parkinson's Disease to

<sup>\*</sup>Bibler Professor of Family Medicine and Director, Undergraduate Family Practice Education, Indiana University School of Medicine.

Part 4 will be presented next month.

Correspondence: Dept. of Family Medicine, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis, Ind. 46223.

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relieve the symptoms. The verdict is not yet in. But, animal experiments look promising.

Wyatt and his group are also transplanting fetal eyes into the optic pathway within the brain to make blind rats see. They have found that the eye and the brain are the only organs that do not quickly reject foreign tissues. This has great potential for re-establishment of hormone production, repair of brains and spinal cords damaged by accident or disease.

Bypass surgery for revascularization of areas of the brain comparable to coronary vessel bypass is being done sparingly now with success and will be bound to increase, as will sophisticated electrical and chemical devices to stimulate and make the brain react in various ways.

The ethics of this can be frightening. It can raise the question in the minds of many suggesting brain control. In the wrong hands it could be just that.<sup>18</sup>

New instruments and techniques are constantly questioned. Take the pacemaker. Is it a rip-off? Ralph Nader says it is. In his Public Citizen Report to the Secretary of H.H.S. he said there is great waste, fraud and abuse by pacemaker companies and by physicians. This makes for headlines and, before the truth is ferreted out and errors corrected, the public believes the accusation. In a Maryland study of 2,222 pacemaker implants of which the Nader group charged 23% were unnecessary and another 13% questionable, the heart specialists who investigated the same cases concluded that only 4.5% were either questionable or unnecessary. That's a far cry from Nader's 36%. As to the costs, the Nader Committee completely ignored the high cost of research and development, quality control and normal marketing expenses. Nader based his costs on time, labor and materials only and omitted the cost of running a business. Allegations of kickbacks have been many and the inference has been that the practice is widespread. Such sensationalizing in the news is the rip-off and has done disservice to the physician, the patients who need pacemakers and to

manufacturer.

But, such is the woe the manufacturers and health care providers must face if progress is to continue.

Malpractice suits can be brought due to some of the complications of use of the delicate and sophisticated diagnostic and therapeutic equipment. I've listed them as described in the books outlining the diagnostic and therapeutic procedures and they would include hematoma, arteriovenous fistula, arterial tears, aneurysm, infection, embolism, allergic reactions, thrombosis, hemorrhage, vascular spasm, leaking around puncture site, dissection of artery, infarction, ventricular irritability causing arrhythmias, and extravasation of contrast materials.

The treatment of some of the conditions in which these complications can occur is so often a palliative measure for an illness that is a continuing and relentless generalized disease with a prognosis before treatment that was undoubtedly bad. These circumstances leave the doctor with little choice but say it ought to be tried. Often the patient and family may be over expecting and if the results are not up to their expectations, they may not think kindly of the doctor for the results obtained.

I shall quote Dr. David Smith once again to lead me into what most researchers and writers on the subject feel is the most important aspect of our entire subject. It is the one point with the potential of adding more ethics and legal safety than any other. It is informed consent—not just consent—but truly informed consent.

Dr. Smith, director of the Poynter Center at Indiana University, in a letter to me on Sept. 16, 1982 in answer to my inquiry, said: "First, an experiment is not therapy. All therapies are risky—some more so than others. Consent is important for therapy and there are times when trust and proxy consent must prevail. But consent is even more important in experimentation . . . precisely because the effects on the body are not to the benefit of the person affected . . .

"Second, consent is not enough. People may volunteer to do some things that no physician in conscience could support; medical ethics can't be just individual rights but involve some kind of reference to an objective norm of health."

Actually, the responsibility of the physician is to possess ordinary skill and apply ordinary care in the treatment of his patient. In professional activities the standard is that ordinary care be "performed by a prudent person of the same or similar training performing the same or similar functions in the same or similar circumstance." The duty of the maker and seller, it seems to me, is to be truthful about their product and sympathetic and understanding to the physician who will use it.

The physician must go further and tell the patient what he is going to do, the results he is striving to achieve, what the potential dangers are and what the complications could be. He must obtain the consent of the patient or guardian. This does not relieve him of the need for ordinary care; but it does give informed consent. Simple consent is given when one merely signs a consent agreement for a procedure or use of a product without actually knowing what he's signing. It differs from informed consent and the patient will not be bound by such a signature unless he's been told of all possible complications or untoward results. In fact, without informed consent, the physician has done an unauthorized procedure and may be open to a suit for assault and battery.19

Let me draw from Dr. Ralph J. Alfidi, as he has written his ideas on informed consent. He said;<sup>20</sup>

"Let us examine the relationship between the physician and his patient who is about to undergo angiography, another special procedure, or surgery. As physicians, we have emphasized the confidence implicit in the doctor-patient relationship. However, disclosure of the risks, complications, morbidity, mortality, etc., that may result from various procedures are not often discussed by the patient and physician. Why? The physician may fear that the patient may decline a necessary procedure or that he may alarm the patient, or the physician may be reluctant to change old habits. It could be argued that most physicians find the truth in lending and truth in advertising laws commendable. By analogy, truth in medicine is no less desirable.

"If it can be shown statistically that most patients desire information concerning risks of proposed procedures, physicians should no longer be reluctant to disclose such risks. The physician who obtains informed consent accomplishes several things: (1) he fulfills a legal obligation, (2) he provides himself with a measure of protection against a lawsuit on the basis of failure to inform, (3) he supplies the patient with information that current studies indicate the patient desires, (4) he may possibly prepare the patient psychologically for complications, and (5) he discharges what might be considered an ethical obligation."

In his study of 1,000 patients Dr. Alfidi obtained informed consent through the use of a form letter and an appended questionnaire which requested the patient to answer questions about the information included in the informed consent document. He said that most patients were grateful to have been informed and felt that they should receive the information. A few even asked for additional information about rare complications. Of the patients who responded to the question, "Do you regard the information as useful?" 782 said Yes, 49 said No.

To the question, "Do you think all patients should receive the information?" 697 said Yes and 120 said No.

To the question, "Do you desire further information regarding specifics of possible complications of the procedure?" 134 said Yes and 679 said No.

To the question, "Has this information caused you to change your mind as to whether to go through with this procedure?" 277 said it made them more comfortable going ahead with it; 326 said it did not affect them one way or the other; 223 said it made them less comfortable; and 10 said it caused them to decide not to go ahead with the procedure.

The consent form, which is to be sign-

ed by the patient, says:

"Dear Patient: Your doctor has referred you for an angiogram, which is a study of your blood vessels. This is one of the most accurate studies we can make concerning the condition of your blood vessels. As with all medical procedures, it carries some risks, about which we think you should be informed. Your doctor is aware of these risks and has determined that the benefit in diagnostic information which may be obtained from the arteriogram outweighs the potential risk of the procedure.

"In this procedure a small tube (catheter) is introduced into one or several of your blood vessels. Through this tube, a solution will be injected which will enable us to see your blood vessels on x-rays. This tube is introduced into a blood vessel, either in your arm or your groin, by means of minor surgery under local anesthesia.

"Patients, understandably, wonder what complications can occur from this procedure. It does involve some minor surgery and it does involve entering the body and the bloodstream. The usual complications, which we consider relatively minor but nevertheless can be distressing to patients, are accumulations of blood in the tissues where the catheter has been introduced (hematoma) or a small outpouching of the artery at the site where it was entered by the catheter. There are less frequent complications which we consider more serious, which might lead to serious damage or to loss of an organ. Surgery may be required to correct the complication.

"Very rarely, complications from the procedure have resulted in death. This has occurred four times in the 6,500 angiograms we have performed.

"Our overall serious complications rate is approximately one in 500 angiograms.

"It would be impractical, and probably misleading to the average person, to describe here in detail all of the complications which might possibly result from this procedure. If you would like more detailed information, we will be glad to discuss it with you."

Complications may run fairly high in

some procedures, thus increasing the risk to the patient and for a lawsuit. For example, percutaneous biliary drainage according to a series of 68 patients resulted in complications in 16 patients, which was 23%. There were two deaths, which amounted to 3%. Hemorrhage occurred in three patients, one of whom died; five had early sepsis, one of whom died; five developed late sepsis; two had a liver abscess and one had bile pleural effusion. Usually this procedure, however, is used on patients with obstructive jaundice most often due to malignancy.<sup>21</sup>

The procedure may prevent patients from major surgery and the author felt the morbidity and mortality were much lower than those who had a surgical bypass. Nevertheless, the risk is there and sometimes patients sue for bad results even though excellent technique had been used and the risk well known and even though the condition for which the procedure was used is almost always a serious ailment. They sue, too, for the "deep pocket"-the company who made the instrument and the company who made the materials that went into the instrument. So, once again, total honesty and full informed consent are necessary preventives for suit and for defense in event of a suit.

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## **Drugs and Insomnia**

### A National Institutes of Health Consensus Report Synopsis

JEAN WOERNER, M.D. Indianapolis

A national survey on sleep disorders found that one-third of the population reported some insomnia and 17% considered it a serious problem. One-half of the 17% reported a high level of emotional stress.

National Institute of Mental Health and the Office of Medical Applications of Research of the National Institutes of Health convened a Consensus Development Conference on November 15, 1983, to attempt to develop principles to facilitate diagnosis and treatment of insomnia.

Consideration of 1) when medication might be considered and what kind of sleep disturbances made medications undesirable; 2) what pharmacologic factors to consider in selection of sleep - promoting medication; 3) what the appropriate treatment strategies are in using sleep-promoting medications on short-term or long-term basis; 4) what the

principal cautions and risks are regarding medical status, age, concurrent drug use, etc.; and 5) what research areas need further development elicited the following recommendations.

1. Treatment should be directed toward the medical or psychiatric condition and if symptoms persist because of pain or discomfort, adjunctive treatment with sleep-promoting medication may be of use. If situational stress can be anticipated as a short-term problem, sleep promoting medications might be considered.

Treatment for long-term insomnia must be evaluated individually. The presence of alcoholism, sleep apnea, daytime sleepiness, or heavy snoring should make one very cautious in prescribing these medicines for long-term insomina.

2. Therapeutic index, dose, rate of absorption, active metabolites, drug interactions, lipophilicity, rate of tissue distribution, clearance rate, and drug effect are pharmacologic factors to be considered. Benzodiazepines were chosen for discussion of these properties since they are most frequently used today.

- 3. Strategies employed should consider transient insomnia, short-term insomnia or long-term insomnia, and should differ for these three classifications. In transient insomnia, treatment might be needed for one to three nights or not at all. In short-term insomnia, intermittent use of drugs might be advisable. Long-term insomnia requires special medical and psychological, and psychiatric evaluation.
- 4. Risks involved vary with the patient, the situation, and the condition being treated! Risks are greater in pregnancy, sleep apnea, alcoholism, patients with impaired renal and hepatic function, and patients on multiple other drugs.
- 5. Research areas needing further development include epidemiologic studies, cost-effectiveness, the process of self-treatment, the daytime performance of insomniacs with and without treatment, somatic, psychological, social, and economic costs of untreated insomnia and the costs of therapeutic approaches, and the function and physiology of normal sleep and the pathophysiology of abnormal sleep, and the search for new and better treatments for insomnia.

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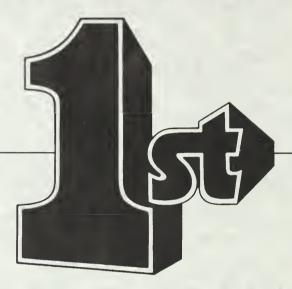
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### COLEMAN HALL

### A Monument to Indiana Medicine

### MADGE DISHMAN Indianapolis

WARFED AND DEPRECIATED by enormous, more noticeable buildings, she remained proud and dignified. Even as sandblasters washed her face, she stood undaunted—like a quaint, little old lady magnanimously patient to the hubbub of men and machines within her walls.

Coleman Hall, for almost half a century known as the William H. Coleman Hospital for Women, has changed.

No longer do her circular driveway and protective portecochere welcome the expectant mother to solace within. No longer does an expectant father pace nervously in her halls. No longer do her walls hear the piercing scream of a newborn.

In fact, a newborn's cry has not been heard there since 1973 when the clinical services and teaching facilities of Coleman Hospital moved to University Hospital's second floor Obstetrics and Gynecology Department. Progress, change and innovations in obstetrics and gynecology left her abandoned in the shadow of the looming new buildings of the Indiana University Medical Center.

An aerial view of the Indiana University/Purdue University at Indianapolis campus, where Coleman Hall is, shows her modest rectangular shape almost lost in a profusion of the other many-winged and multi-layered outlines. But the accomplishments of Coleman Hospital for Women were not modest.

The Indiana University School of Medicine, as well as the city of Indianapolis and neighboring communities,



William H. Coleman Hall

was fortunate in receiving the gift of a maternity hospital from Mr. and Mrs. William H. Coleman. This gift, totalling \$300,000 in real estate and money, was unprecedented in the history of the School of Medicine.

The William H. Coleman Hospital for Women was the first obstetric and gynecologic hospital built in Indiana. It was one of 12 such hospitals in the United States when opened in 1927.

Although named after Mr. Coleman,



the hospital was dedicated to the memory of the Coleman's daughter, Suemma Vajen Coleman. She died in April 1924 of a chronic renal disease, a complication of her only pregnancy.

At the time of dedication on October 29, 1927, there were eight patients already receiving care. The first baby born in Coleman Hospital was named Coleman Oertel, of New Palestine, and years later he received a \$5,000 education fund in Mrs. Coleman's will.

With 64 beds (exclusive of the nursery) and 22 private rooms, Coleman Hospital was described as "one of the best modern examples of a well arranged and equipped hospital for lying-in patients." Mr. and Mrs. Coleman wanted the hospital to be a "teaching hospital, helpful in training physicians and nurses who would carry the beneficent influence of the hospital throughout the state and nation."

In the 47-year history of the Coleman Hospital for Women, more than 2,500 student nurses received maternity training. All Indiana University medical students from the classes of 1928 through 1973 learned to do their first normal

deliveries at Coleman. Postgraduate and residency training were also important endeavors.

It is ironic that the very principle of Coleman Hospital's existence eventually caused her abandonment. Education and research brought progress, change and innovations in obstetrics and gynecology.

Times changed; the 1927 "modern example of a well arranged and equipped hospital" became outmoded by 1973. The classes of the Indiana University School of Medicine outgrew her limited space. She could not meet with minimum fire codes for a hospital.

So instead of the piercing cries of newborns, her walls echoed sounds of hammers, saws and drills. Instead of an antiseptic smell, her corridors took on an aroma of new wood and paint.

With a washed face and newly draped windows, still dwarfed by her neighbors, she now stands proud and dignified. There is a self-satisfied look in the wide, broad-shouldered structure that seems to say, "Through these open doors, I welcomed all in need of my care and I sent out into the world 70,000 new lives. Do what you will with me; I have served my purpose."

Coleman Hall continues to serve the citizens of Indiana and is still dedicated to education. The Division of Allied Health Sciences of the Indiana University School of Medicine now makes its home there.

The Allied Health Sciences is an array of studies related to medical science, such as respiratory, physical and occupational therapy. Coleman Hall houses classrooms for these fields as well as medical records, administrative and faculty offices. The IUPUI campus Student-Employee Health Services occupies half of the first floor.

Renovation cost \$2.5 million. The original 1927 exterior was polished through sandblasting and refinishing of window casements and door woodworking. But the interior was modernized by changing central hallways and room layouts to meet safety codes.

Modern educational standards dictated the choice of equipment and structure of the second floor classrooms and





Through these doors, I welcomed all in need of my care and I sent out into the world more than 70,000 new lives.

laboratories. The wall mural in the former 34-bassinet nursery, painted by local teenagers, now is replaced by a color-coordinated decor. The white delivery room on the east end of the third floor is now a classroom in tones of green.

Even the landscaping was changed and Coleman Hall lost the legendary "May Tree." Those who remember the tree say that Mrs. Coleman brought a seedling from one of her trips to Europe and planted it near the east wing of Coleman Hospital. It was supposedly one of two such trees in Indianapolis. Its lavenderpink blossoms were always out by Derby Day.

The "May Tree" is gone, but a similar beauty remains in the flowering crabapple trees that line Michigan Street in front of Coleman Hall. The William H. Coleman Hospital for Women is gone, but the education and service for which she was built goes on within her walls and through the Obstetrics and Gynecology Department at University Hospital.

Mr. Coleman must have realized before he died in 1946 that his hospital was serving the purpose he had built her for. He was a self-made wealthy man who gave more than \$1 million in charitable gifts to benefit the citizens of Indianapolis and neighboring communities.

Six months before his death, the *Indianpolis Times* printed this tribute to both the Colemans: "Mr. and Mrs. Coleman have supported so generously every project that meant relief or rehabilitation for the unfortunate that their name has become synonymous with giving."

In December 1946, at the age of 98 and after almost a century of giving, Mr. Coleman took back only one week of the care and aid he had made possible. A healthy, robust man until that time, he died of pneumonia in a room on the west end of the second floor of Coleman Hospital.

He was reported to be the only male patient ever admitted to the William H. Coleman Hospital for Women.

## Why A Dues Increase Now?

### A Message from the Executive Director

ITHOUT THE FINANCIAL SECURITY of an increasingly solid monetary base, your Association cannot grow, cannot assert the kind of leadership that is clearly necessary to implement aggressive programs and effect appropriate changes in the provision of medical care to this and the next generation of Hoosiers.

Your Association survived the past nine years without a dues increase partly because of the fact that membership dues constitute only about 54% of 1SMA's total income, and partly because of investment income and other miscellaneous sources (advertising, convention exhibits, administrative services, etc.). But it was mainly due to the efficient management of finances and personnel that your Association was able to underspend the budget, while increasing membership programs and benefits, during Fiscal Year 1983, even though we experienced 76% cumulative inflation in the general economy since 1975. However, in Fiscal Year 1983-84, the Association is working under a projected deficit budget of \$35,000.

The current dues level of \$181 was established in 1975. In 1982 the House of Delegates approved a special purpose, two-year dues increase of \$25 which expires this year (1984). As a consequence, ISMA dues for 1983 and 1984 were \$206 but will revert back to \$181 in Fiscal Year 1984-85 without further action by the House of Delegates.

Before leaving the issue of the special two-year dues increase, I believe you should know what happened to the money in the special dues account. A total of \$240,000 in dues money has been collected thus far from 1982 and 1983 dues payments. The ISMA expended approx-



DONALD F. FOY
Executive Director
Indiana State Medical Association

imately \$30,000 in legal fees from the account in obtaining legal advice on whether to litigate the Blue Cross and Blue Shield VIP program, leaving a balance of some \$210,000. And just recently the Board of Trustees approved a two-year, \$200,000 public relations program consisting of positive media messages designed to position physicians as patient advocates in the public's mind. The Board further authorized an expenditure of \$88,000 for the current fiscal year to fund the initial phase of the campaign to be charged against the special dues account.

Now let's take a look at the \$181 dues structure of 1975 and see what inflation has done. Applying an inflation factor of 76% against the \$181 dues reveals that the 1975 dues are worth \$81 in 1984. The accompanying bar graph illustrates the

erosion that took place during the period 1975/1983 due to inflation alone.

In order to support the Association's increasing level of activities and programs for fiscal year 1984-85, the Executive Committee is recommending a \$54 dues increase which would raise ISMA dues from \$181 (the 1975 level) to \$235. Recognizing the importance of the legislation and regulations on medical practice, this would permit the Association to hire two new legislative assistants and an additional half-time staff equivalent in public relations.

Some of the projects that the ISMA officers, commission members and staff are currently involved in include: a review of the mechanisms of direct and indirect advertising of medical services in Indiana; developing a presentation to inform the membership about such alternative medical care delivery systems as HMOs, PPOs, and IPAs; a statewide public information campaign positioning physicians as the patient's advocate; developing a Peer Review Organization for Indiana; review of the Patients' Compensation Act by the Malpractice Advisory Committee in order to develop recommendations for changes that may be necessary; meeting with senior citizens' groups to discuss problem areas such as health care costs and explaining Medicare; lobbying on important national and state issues such as Medicare assignment; monitoring the DRG Program, etc. These special projects and programs involve specific issues and events of immediate concern to the membership and are being addressed in addition to the routine activities of your Association.

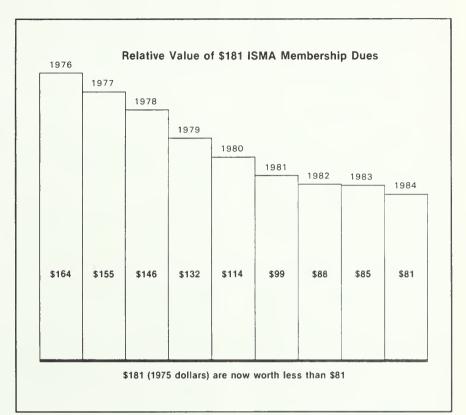
Commissions and staff members continue to work in such vital areas as monitoring meetings of the Medical

Licensing Board and the State Board of Health, and reviewing all state and federal rules and regulations which could affect medical practice. ISMA is active in the areas of sports medicine and Indiana's high school athletes, geriatrics and nursing homes, public health, continuing medical education, members' health, life and professional liability insurance and financial planning, public relations, and more.

You will be interested to know that the proposed dues increase of \$54 will still keep ISMA's fiscal year 1985 dues below our neighboring state associations which are as follows:

Illinois — \$253 Michigan — \$290 Kentucky — \$300 Ohio — \$240

If you have any questions regarding any aspect of ISMA finances, please contact any of us at ISMA headquarters. A more detailed presentation will be made to the Reference Committee at the ISMA annual meeting in October.



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# EDITORIALS

### Readership Survey Results

Thanks to 293 of 500 Indiana physicians who responded to a recent readership survey, we now know that an average issue of INDIANA MEDICINE is read by 68% of ISMA members.

The survey, conducted by a private firm, Health Industries Research of Stamford, Conn., revealed that INDIANA MEDICINE is read thoroughly by 65% of its readers. That's important information for advertisers because thorough readers are more likely to see an individual ad page.

A qualitative evaluation of our magazine showed that 92% of our readers wish to continue receiving it. And on a scale from 1 (low) to 5 (high), we received an overall quality rating of 3.5.

Why do Hoosier doctors read IN-DIANA MEDICINE? The survey said that 72% of readers are mostly interested in the clinical articles written by Indiana physicians. Over half of readers said one of their reasons for reading it included news of people and Association news. News of events attracts 49% of our readers and CME articles attract 48%.

The features most widely read are the clinical articles (91%), the CME articles (89%) and the What's New? column (88%). These are followed by Medical Museum Notes (80%), editorials and commentaries (77%), Future File (67%), Obituaries (65%), president's or executive director's message (62%), Public Health Notes (61%), new Association members (55%), Physicians' Directory (54%), ISMA commission reports (50%), Book Reviews (49%) and Commercial Announcements (37%).

Readers were asked to evaluate the CME articles—one is published each month—and the majority (74%) found the level of difficulty about right. However, of the physicians reading the CME articles, 90% indicated that they seldom or never apply for CME credit.

Of the approximately 5,700 Indiana physicians who receive INDIANA MEDICINE, membership records indicate that more than 1,400 are family physicians, 550 are internists, 335 are obstetrician/gynecologists, 390 are general surgeons, 300 are anesthesiologists, 265 are pediatricians and 225 are radiologists.

Also among our readers are 240 or-

thopedic surgeons, 200 ophthalmologists, 200 psychiatrists, 160 pathologists and about 130 urologists. With about 100 in each category are cardiovascular disease specialists, general practitioners, emergency medicine specialists, otorhinolaryngologists and diagnostic roentgenologists. And, although their numbers are lewer, we have readers representing at least 50 other specialties.

We certainly can't please all of our readers all of the time, but apparently we're pleasing some of them part of the time. That's enough to make the task worthwhile and rewarding.

### Califano on Health Care

Joseph A. Califano, Jr., former secretary of HEW, is now chairman of the Committee on Health Care for the Chrysler Corporation board of directors. He is calling for a change in our health-care system and points to the auto industry to lead the way. Califano urges business and labor to negotiate health-care benefit plans "which are designed to spur competition in the delivery of health care."

Previous union negotiations produced a health-care package which was as loose as a goose financially with first-dollar coverage and no incentives toward prudent use of rare and costly diagnostic and treatment facilities. It is estimated that each American-built car now contains within its price enough medical-care dollars to have bought the car outright 25-30 years ago. This is the best place, and probably the only place, to reverse the present run-away inflation of the cost of medical services.

### **Child Passenger Safety**

National motor vehicle accident statistics in regard to involvement of children in deaths and disability serve to emphasize the importance of Indiana's child protection law. Nearly 3,400 children under 5 years were killed and more than 250,000 were injured between 1978 and 1982 while riding as motor vehicle passengers.

Almost 90% of the fatalities and 67% of the disabling injuries could have been

prevented by the proper use of child safety seats, according to a report by the National Technical Information Service of the U.S. Department of Commerce.

The report examines the use and crash performance of child safety seats, the economic costs of child passenger deaths and injuries, and child passenger protection laws—benefits, limitations, and loopholes. The elements of an effective child passenger protection law are presented.

Copies of the report may be obtained for \$14.50. Order by number and title: PB83-917005/TCV, Safety Study—Child Passenger Protection Against Death, Disability, and Disfigurement in Motor Vehicle Accidents. NTIS, 5285 Port Royal Road, Springfield, Va. 22161.

### **Nuclear Waste Disposal**

The safe and timely disposal of low-level radioactive waste which results from use of radioactive elements in medical diagnosis and treatment and for biomedical research is an important activity which is in the process of being organized and regulated by federal and state law. The American College of Nuclear Physicians (ACNP) has a Speakers Bureau and will provide speakers without charge for major meetings of all medical specialty societies, state and major county medical societies and other health-related organizations.

According to the Federal Low-Level Radioactive Waste Policy Act of 1980, each state must pass legislation either to enter into a regional compact for disposal or to establish its own facility by January 1986, or the generation of waste within its boundaries must stop.

The ACNP is impressed with the low level of nuclear energy information among the population at large. This deficit starts with lack of knowledge as to the importance of various nuclear agents in diagnosis, extends to a lack of appreciation concerning the value of nuclear energy in treatment, and finally involves the safe disposal of nuclear waste (either low-level or very low-level) which is left over when the medical mission has been accomplished.

The waste management problems must be solved, else all the medical uses of nuclear energy will be terminated.

Physicians should be aware of the problems. They should organize educational seminars at large county, district or state meetings. National medical specialty societies should do likewise. And, more importantly, physicians should be alert to the duty to inform program chairmen of health-oriented organizations, luncheon clubs, and all public information media, concerning the possibility of obtaining well informed and talented public speakers for this most important and highly interesting subject.

The American College of Nuclear Physicians is headquartered at 1101 Connecticut Avenue, N.W., Suite 700, Washington, D.C. 20036. The phone is (202) 857-1135. Ask for Barbara C. Teele, Educational Coordinator.

### Hepatitis B Vaccine

A new vaccine for Hepatitis B, produced by recombinant DNA, has been tested and found to be effective. The production method is important because the amount of vaccine produced will not be limited by shortage of suitable plasma, and will be free of any extraneous living agent that might be present in the starting plasma.

The JAMA article which reported the new vaccine states that immunizations with the plasma-produced vaccine have been considerably less in number than was expected, probably because of the fear of acquiring hepatitis or AIDS.

### The Odd Couple

### **Guest Editorial**

Physicians generally have an uneasy feeling about lawyers. There are a few exceptions of circumstance, perhaps—when, for example, legal services are needed in maneuvers such as malpractice defense or countersuits. There are even occasional instances of social rapport when professional differences are, fortunately, muted. At the organizational level, the respective parent groups issue intermittent announcements that there are no real differences of attitude or purpose between them—and anyway they are trying to work them out.

Meantime (this to keep peace in our editorial family), a small but increasing number of renegades from both camps are acquiring the academic qualifications to serve either side but their intent seems not so much to reconcile their respective philosophies as to gain the inside track in confronting their opposite numbers. Physicians generally, as we said in the first place, have an uneasy feeling about lawyers.

Although the medical profession needs no particular reminder of the progressive intrusion of lawyers into its functions, we have recently become aware of a group whose emergence was probably inevitable, the National Health Lawyers Association. It is not surprising that such a group exists. A prime national characteristic is that when two or more individuals can find a common denominator, they feel compelled to organize, complete with constitution, by-laws, and an annual dinner meeting with the spouses. The fact is that this organization represents a sort of maturation, a recognition that matters of health are so extensive, so much a part of the national scene, and so productive of legal questions that the united interests of the legal profession demand this type of forum.

This is not in any way to object to such an organization or see deliberately ulterior motives, either of presence or purpose, in its existence. The generality of its title leaves room to believe that it may have interest-even positive benefit-for physicians, particularly those immediately involved in negotiations of medicine with various social and political entities-and that's a lot of territory. Our interest, rather, was attracted by the remarks of one of their members at a recent meeting regarding the progression of changing attitudes in the antitrust climate as it is affecting the medical corps. It was not so much the details (we need to save some of them for another time) as the implications for one limited phase of medical activity, hospital staff selection.

Physicians have, in the past, been accorded—and accepted as a basic right of the profession—the responsibility of passing on the professional merits of staff membership applications and, consequently, reappointments. It was generally assumed that, being familiar with the

needs, acquainted with the intricacies of professional preparation and qualification, and generally supportive of a high quality of function, they knew how to do this best. Professional interests were better served not by prostitution of the process but by adherence to objective standards of quality. By and large, hospital boards accepted their recommendations and generally confined their attentions to the incoming bills, the administrator's ambitions, and the balance sheet.

No more. As hospitals conglomerate and medical staff activities become an administrative unit in a complex of services (albeit an important one), it is an increasing certainty in the legal mind that there is an abiding conflict of interest for physicians in choosing their peers or judging their functions, that what the physicians thought of as qualifications for such judgments were actually grounds for exclusion from it, and that only the hospital administration and board (with legal guidance, of course) had the combination of vision and objectivity to make such determinations. The idea has been fostered to some extent by disgruntled physicians denied appointment or reappointment, sometimes justified, sometimes not, for which judicial intervention has been sought, sometimes successfully, sometimes not.

The remarks referred to (and presented, as mentioned, in greater length and detail) are not so much revelation as confirmation of the situation which is well past the trend stage. Physicians have seen with varying clarity the development of such attitudes but have been relatively impotent to offset them, given the state of social pressures. Although this represents but one limited phase of the altered physician-hospital relationship, the process has reached a pervasive level: physicians will be increasingly pressed to accommodate their professional integrity to what are seen to be legal realities. At the very least, it is another expression of the direction in which medical influence is moving as the relentless repositioning of the physician in the medical effort is accomplished. Plus a need for more physicians to go to law school.—David E. Gray, M.D., The Journal of the Kansas Medical Society, May 1984. Reprinted with permission.

# EDITORIALS

# DRG Means Split the Fee Guest Editorial

Medical services and level of care has undergone a 360 degree revolution and now is faced with a recommended repeat 360 degree turnaround.

In the pre-specialty era of the Thirties and Forties the family doctor practiced as though he was shipwrecked on a desert island. He saw each case through to the end and was limited only by his knowledge, experience and awareness. Many general practitioners of that vintage practiced surgery, obstetrics, internal medicine, orthopedics and all special areas to the best of their judgment.

With the advent of specialty boards and sub-specialty boards, primary care physi-

cians began to transfer high-risk patients to appropriate experts.

The increase in professional liability or malpractice responsibility also resulted in transfer of those potential high-risk patients to the "best available source of special medical care."

Gradually, the family physician diminished his involvement in general surgery, high-risk obstetrics, orthopedics, cardiac management, neonatology and the like. However, with the maintenance of his responsibility for the ultimate outcome and his role as the stabilizing force, his fees did not significantly diminish and the fees of the super-specialists were added on as justifiable maximum top-notch medical care.

This satisfied the goading of the news

media—in its insatiable goal to inform the public of what they needed and deserved. Not being responsible for that cost gave them little concern for analysis of the resultant yield from exotic procedures.

Patient care flourished with high technology, but at the resultant sacrifice of the stabilizing influence of the primary care physician as patient advocate and friend.

Patients subsequently were trained to run to high cost sophisticated hospital Emergency Rooms and now with the physician glut the newly created "Doc in a Box" neighborhood convenience store is on the horizon.

These are ideal if the consumer patient is knowledgable and educated satisfactorily to know how, when and where to enter the medical millstream. But woe to the patient who upon wakening with a headache, first consulted the Yellow Pages for a neurosurgeon and rightly so, ends up with a full fledged neurosurgical workup—more than is needed but useful for protection of the physician from malpractice risk.

If the DRG principle is enlarged to include physician fees in addition to hospital bills, the finances will be further complicated.

Now comes the full 360 degree reverse psychology and philosophy. With DRG and other indemnity limits for the monies available for medical care reimbursement, the primary care physician will have to attempt to solve more problems single handedly, rather than share those limited resources with cost-Unconscious superspecialist consultants.

If the DRG or other indemnity allowance pays only one total medical fee to one provider, it will change the entire medical referral philosophy. For example, if DRG allows \$2,000 total for medical and surgical care for gallbladder surgery, then the attending physician will be tempted to negotiate for the lowest bidding surgeon and pay him directly; in contrast, if the surgeon is the primary physician, he may elect to operate without a surgical assistant or without general medical consultation in order to increase his percentage of the total fee allowance. In other words, some physicians will become health care brokers with commissions and fee splitting.

### Safety vs. Efficacy

**Guest Editorial** 

The 1962 Amendments to the Food Drug & Cosmetics Act requires the FDA to evaluate the safety and efficacy of new drugs before they are released for marketing to the public. As most of you know the Kefauver-Harris amendments were enacted into law as a result of the Thalidomide disaster.

Some observers think that the main reason for the change in the FD and C act was to test the drugs more rigorously for safety and the word "efficacy" was added as an afterthought. At that time, even the most astute industry executives did not realize the vast changes that were to come about in the industry because of one word - EFFICACY.

What followed is too well known to be discussed here. The DESI program, removal of thousands of heretofore well accepted drug products from the market and so on. But the slow down in the introduction of new drug products in the U.S. market was the most disturbing result. American drug manufacturers were introducing drugs with significant therapeutic advantages in other markets while their American NDAs were bogged down in the FDA's cumbersome review process of judging 'efficacy' of the drug. The extensive clinical testing of the new drugs became an obsession with the FDA

officials and the issues of efficacy perhaps overshadowed the problems of drug safety and public health.

Mr. Christopher DeMuth, chief of the office of Management and Budget recently suggested that what is needed is a fundamental reform of basic regulatory statutes. One of his examples dealt with the FD & C Act. He opined:

"Rewrite the Food, Drug and Cosmetic Act to emphasize health and safety protection rather than government approval of the 'efficacy' of pharmaceutical and medical products. Permit considerations of costs and health benefits in making cosmetic and food-additive decisions; streamline cumbersome medical devices classification scheme, and reduce or eliminate FDA's role in naming foods (what is a 'noodle'?)."

It is our contention that if the product lacks efficacy in therapeutics, it will disappear from the market because no one will prescribe it. There is no doubt in our minds that the new drugs must be tested for efficacy but more emphasis should be placed in studying the safety of the drug products, not only on pre-marketing phases but also *after* the drug has been released in the market.

Safety first—the saying might be old, but it is as applicable today as it has ever been in the past.—"Action in Pharmacy" newsletter, Kansas City, Mo.

This will cost contain and further follow our government's trend, which I have labeled—"The Quest for Mediocrity."

If the patient is not knowledgable to challenge these physicians and if his use of health care resources is controlled by law, the providers will gradually reduce their caliber of care to the level they judge that the patient can afford or understand.

This will result in intermediate or low technology to the masses, which will be satisfactory for most, but catastrophic to the small population needing exquisite expertise.

It has been stated that America waits for a program to fail in England and then adopts it for the USA.

To generalize an example, let us reflect on one aspect of the National Health Service in Britain.

For the first 25 years of the program, the providers were the dedicated doctors, nurses, and hospital personnel of the old school—they took the pride and responsibility of their roles and stayed after 5:00 in order to assure satisfactory care to all patients.

England is now being served by the second and third generation of physicians who personally grew up under these impersonal structured services of the National Health Service. Not knowing the

contrast, they can only understand the "system" approach to care and services. This may be very satisfactory to the masses, but it raises the question of how does the exceptional case receive care and appropriate assessment without being lost in the turnstyle.

I grant this may be over-simplified and generalized, but the unassumed challenge is there.

Diagnostic acumen in medicine is usually broken down according to the following pattern: Clinical history gives 60% to the diagnosis. The physical examination and findings, without history, give the next 20%. All the laboratory, x-ray and special studies offer new diagnoses as 10% of the total work-up. Such studies generally confirm the clinical impression of the attending physician.

These modalities total 90%—the additional 10% is labeled as the "Art of Medicine"—the moxie, the savvy, the intellectual prowess of the physician in correlating these findings. That's what separates the men from the boys in the "Results" game of medicine.

In concluding this rambling of medical history, the 360 degree reversal precipitated by TEFRA limitations will result in jealous possession of the patient, guarded utilization of the funds available, and a level of "satisfactory" average care for most

This dilution and diminution of maximized high technology services for any and all will also result in cost-effective attacks on many of our areas of quality control—namely, uniform level of hospital care and services as monitored by the AMA and JCAH, and control of credentialling of specialists by specialty bond societies. Responsibilities of professional liability will be changed because of legislated cost regulation, and decreased enthusiasm of physicians to undertake high risk exceptional cases.

If mandatory acceptance of assignment becomes Medicare law, and balance billing is disallowed, then groups of hospital-based physicians, groups or corporations will arise and patients will lose the continuity of private attending physician care for the entire illness. The family doctor will no longer be the quarterback of the medical team—choosing consultants in the best interest of the total patient.

In other words, in conclusion, DRG means split the fees. The consumer will be left to the manipulation and negotiations of government, the insurance industry, the employee or union benefit profiles and the health care providers with the hapless citizens as the ping-pong ball consumer.—C. Dyke Egnatz, M.D., Schererville

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# EDITORIALS

# Breast Cancer and Normal Mammograms

**Guest Editorial** 

Mammography has proved to be a valuable aid in the diagnosis of early breast cancer. It is particularly useful in high risk patients in whom very small cancers may sometime be identified before they are palpable.

Unfortunately, mammography is not foolproof. Many patients with breast cancer have normal mammograms. The lay public and many primary care physicians are not aware of this fact even though it has been repeatedly documented in the surgical literature. This lack of awareness may lead to delay in treatment of the cancer.

I reviewed my experience with breast cancer for 1983. There were 28 mastectomies for breast cancer. Of these 28 patients, 19 had preoperative mammograms. Six of these 19 patients (31.6%) had normal mammograms. These six false-negative studies were done in four different departments of radiology and no two were interpreted by the same radiologist.

The purpose of this editorial is to emphasize these already well established facts: (1) a normal mammogram does not guarantee the absence of breast cancer and, (2) every suspicious breast lump should be removed regardless of what the mammogram shows.—McHenry S. Brewer, M.D., Journal of the Kentucky Medical Association, May 1984. Reprinted with permission.

### International Request

Letter to the Editor

I am working on a case of full-term abdominal pregnancy with no complications to mother or child. I would be greatly indebted to you if you could kindly forward to me a copy of the following paper:

"Abdominal Pregnancy, Full Term: A Case Report and Review of the Literature," by E. T. Banguis, M.D. and T. A. Jean, M.D., *J Indiana State Med Assoc*, 71:3, 330-332, March 1978.

Thank you very much. Yours truly—Ares Petropoulakis, M.D., Athens, Greece

### **Malpractice Awards**

**Guest Editorial** 

Doctors all over Indiana face a large increase in malpractice premiums for the coming year. Our malpractice law anticipated that some awards to plaintiffs would be large, so a contingency fund was established from which such exceptional payments could be made. A surcharge of ten percent of the premium was supposed to take care of the problem.

Ten percent was not enough; recently, we have been paying twenty-five percent over the standard premium of many thousands of dollars per year. But payouts have been so huge that the fund of \$11,000,000 is almost depleted; next year, we shall pay a 50% surcharge over our usual premium.

We are better off than the obstetricians in Long Island; there, a doctor who delivers babies must pay a premium of \$60,000 per year to his insurance company. When a handicapped baby is born,

the doctor is blamed until he can prove in court that it was not his fault.

One plaintiff was awarded \$800,000 because her bellybutton was two inches off the centerline. Her plastic surgeon commented, "I wonder what she would have collected if I had really hurt her."

A plaintiff's attorney in Florida—where the loser pays the attorneys' fees—submitted a bill for \$1,400,000 for his services. He argued that if he had spent the amount of time that he could have spent on a case of that difficulty, and if he had charged \$2,650 per hour for that time, he would have earned a fee of \$1,400,000. The judge—who was also an attorney—saw nothing pecuilar about that reasoning, and awarded the requested fee.

It is impossible for us to buy insurance to cover pain and suffering, and it is unfair for plaintiff's attorneys to demand that doctors and hospitals pay for pain and suffering. Awards should be made only for permanent injury.—H.C. Moss, M.D., Indianapolis

### The Old Order Changes

Commentary

Here are a few random thoughts on our methods of medical education and hospital training. These have recently changed greatly. Some changes are for the better and must not be lost. Many changes have been gained at a definite cost. A nostalgic glance suggests that some of the old days should be brought to the attention of the newer generations. The new ways should not and probably cannot be changed. This review discusses some of the advantages of old methods, advantages which the new system does not possess.

The discussion might begin with the present trend to shorten the medical course. The reasons for this are obvious. Medical training is indeed a protracted affair and any true and logical shortening seems desirable. This would allow for early specialization in fields far more complicated than they were a few years ago. Yet, who can say how specialized an M.D. should be. There are those who are convinced that if a young doctor is going directly into nuclear medicine or public health he needs to know little anatomy nor need he ever have delivered a baby or sewn up a simple wound.

A list of these useless acts, both clinical and in the laboratory, is endless if applied to certain medical specialties. On the other hand, to whom are we going to designate the term Medical Doctor—he who has but little interest or experience in human medicine or one who has specialized himself completely out of our profession? Would it not be better to designate the latter, a Doctor of whatever his training has been, but not Medicine. In the past the M.D. has always been a medical doctor; let him remain so.

There can be no doubt that our present-day students are far more knowledgeable than we. That knowledge is more readily absorbed via movies, canned lectures and video tapes. It is often gotten the easy way, sitting down and watching. Yet one cannot but wonder if that is better and will last as long as the old drudgery in laboratory and clinic, rubbing shoulders with the inspiring and the not so inspiring but faithful teacher.

There were certain past routines of interns, residents and staff which had definite value and worth. They will not return but it is interesting to reflect on their merit. The house man did his own laboratory work and finished the simple urines and blood counts before rounds. Probably the present technicians are more accurate and certainly the complicated chemistry of today is far beyond the present house officer. Nevertheless, his predecessor was responsible for this part of his patient's care. It brought him closer to that patient. He took x-rays of broken bones at night as well as administering anethesias. Admittedly, these tasks are better carried out by specialists but at the same time our present house man is losing part of his close-knit patient responsibility. Who has seen an intern examine a blood smear or urine during the past two decades, day or night, and x-ray reports are taken by phone. The myriads of sophisticated laboratory determinations preclude any thought of return to the earlier era.

The present house man orders a chest plate without listening to the chest and it must be admitted that in his particular case this is far more accurate. There

follows an order for a barrage of chemical determinations with little thought of their actual need and that many are repetitious. The present trend is to order all conceivable laboratory procedures or something might be missed and thus draw criticism. Cost is no item. Yet in so doing, our young doctor *is* missing something in that he has lost all sense of discrimination, and that is not good medicine.

One more feature of present versus the past is difficult to understand in the teaching hospital. That is pay for service on the part of the house man, and staff for that matter. Unquestionably, it was absolutely wrong for hospitals of the past to take advantage of the free market in interns but by the same reasoning it is just as wrong for bargaining agents of residents to ask and get thousands of dollars a year "to maintain finest quality medical care." The grimey and shoddy corridors of a large General City Hospital did not prevent "quality medical care." No institution had more unified devotion to patients with loyalty to duty and service on the part of the staff. It was every

other night off (hopefully for sleep) if the work was done. The present two or three nights off and one on had not been seriously considered—and all this for four meals a day and three well worn white suits but—no money changed hands. Those few institutions who needed to "bribe" their inside staff were considered inferior. The long hours of the visiting staff were also without remuneration. This gave in return a proud feeling that our medical heritage was being carried on as it had by the past greats.

Now all this has changed and of course should have, but perhaps not so much. Even the visiting staff man who gladly gave his time so freely is becoming the vanishing American and is paid. Everyone expects money, from the institution, insurance or, of course, the government. Maybe this is right but it immediately commercializes a grand old profession and puts it on the same level as its salaried brothers. The old order changes and those who have had no part in the past have missed an invaluable experience in life and history.—Frederic W. Taylor, M.D., Indianapolis

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# AUXILIARY REPORT

Judy Koontz (Mrs. James A.) President, ISMA Auxiliary

The AMA is launching an election year campaign called "Project Medvote." It is aimed at registering all eligible medical family members prior to the November elections.

This registration effort will be spearheaded by each state auxiliary with assistance from the AMA, ISMA and, hopefully, county societies. Phone, mail and personal contacts will be made to encourage non-registered medical families to participate in the voting process. "Together we can make a difference" by voting for candidates who are as concerned as are medical families about health issues that affect all the people of our country.

### **AMA Auxiliary Convention**

The ISMA Auxiliary was well represented at the annual AMA Auxiliary Convention, held in June in Chicago. This year our membership increased, thus increasing our delegate allocation to 10. Representing Indiana were Mary Jo Gutwein, Judy Koontz, Alfrieda Mackel, Suzanne Miller, Muriel Osborne, Vivian

Priddy, Marge Smith, Martha Stout, Joanne Tharpe and Anne Throop.

We wish to thank Drs. Everett Bickers, George Lukemeyer and Malcolm Scamahorn for allowing their spouses to participate as alternate delegates. We also extend our thanks to Rosanna Iler, ISMA Auxiliary liaison, who also attended the convention; we appreciate all that she contributes to the Auxiliary through the generosity of the ISMA.

The convention, complete with reference committee hearings, was informative, educational and exciting. Discussions included AMA-ERF, health, legislation and membership.

### Leadership Conference

The Indiana Auxiliary Leadership Conference will be held Sept. 25 on the grounds of the Indianapolis Art Museum. A training program is being planned for all potential county leaders and interested members, especially officers and committee chairmen. Besides an exchange of ideas, topics will include health, legislation, AMA-ERF, membership and

fellowship. We hope doctors will encourage their spouses to participate.

### Elections

At the AMA-A convention, Marge Smith (Mrs. Philip) was elected to the national nominating committee. Marge, who is the ISMA-A Bylaws Committee chairman, has held numerous offices and chairmanships and has been an involved auxilian for many years on Allen County, ISMA and AMA levels. We are very happy for and proud of Marge and her recent election to this important committee.

Judy Koontz was appointed as an ad hoc member on the national Long Range Planning Committee.

# Coming Soon . . .

We hope both you and your spouse are planning to attend this year's ISMA convention at the Radisson Plaza Hotel in Indianapolis. The dates are Oct. 19-22. The Auxiliary has planned optional activities for spouses on Saturday morning and on Sunday, which is AUXILIARY DAY. We hope to see you there!

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# BOOK REVIEWS\_

# Basic and Clinical Endocrinology

Edited by F. S. Greenspan, M.D., and P. H. Forsham, M.D. Copyright 1983, Lange Medical Publications, Los Altos, Calif. 646 pages, softcover, \$25.

Like all the Lange Medical texts, this paperback updated text is a bargain. Much new knowledge about the chemical and immunologic aspects of the various hormones is presented. Much of this will be difficult for older physicians to grasp. Yet a little of it sinks in if one will take the time to absorb it, and what one *can* understand will surely be useful in confronting endocrine problems.

One stands in wonder as he learns of the new facts and concepts which endocrine researchers are discovering. We learn, for example, that receptors on all membranes respond to a variety of hormones. The responses of the cell are determined by this interaction. Some hormones such as thyroxine and steroids react chiefly with intracellular receptors in the cytoplasm; some go on to stimulate the nucleus. Other receptors reside in the mitochondria. Sometimes new proteins are synthesized in the cell and these are responsible for the specificity of cell function; other polypeptide and amine hormones do not require synthetic events. There are other mechanisms of action not yet discovered.

In the chapter on prostaglandins the structural formulae leave this reviewer behind, but I found other material about these omnipotent cell stimulators of great interest. Although they were first isolated from human prostate, they are widely distributed in a variety of tissues. They



are synthesized in cell membranes from polysaturated fatty acid precursors. Their regulatory functions are performed in the same anatomic site in which they are produced. Some of the classic hormones accomplish their regulatory roles by inducing prostaglandin synthesis or breakdown.

Closely related are thromboxane, first derived from blood platelets; HETE again derived from platelets but having arachidonic acid as its precursor, and leucotrines, initially derived from leukocytes.

Among the many clinical effects attributed to prostaglandins are increase in renin and aldosterone, hypokalemia, uterine cramping, headache, diarrhea, coagulability of platelets, microvascular damage, hypercalcemia, pain in joints and muscles.

Many of the unpleasant effects of the prostaglandins and associated substances are alleviated by corticoids and also non-steroidal drugs such as aspirin, Indocin and ibuprofen.

In the chapter on the endocrinology of pregnancy one finds useful information on the risks when pregnant patients have pituitary adenoma, breast cancer, thyroid disease and/or diabetes. Breast cancer complicates one in 1,500-5,000 pregnancies. It now appears that pregnancy is not an etiologic factor in breast malignancies. However, increased size and consistency of breast tissue make detection of cancer more difficult. Once discovered in pregnant patients, the cancer should be removed surgically, preferably by radical mastectomy for information about involved axillary nodes. If surgical staging reveals the need for adjuvant therapy, the decision must be made between abortion at once or allowing the pregnancy to go to term. If the latter option is decided upon, all chemotherapy should be discontinued or postponed until the baby is born. Women who have had breast cancer are advised to postpone pregnancy for five years. Pregnancy is not known to influence the rate of cancer recurrence. However, during the five-year period metastatic disease requiring chemotherapy may arise. Also the patient may have attained an age at which possibility of congenital defects in the fetus becomes a hazard.

True hyperthyroidism of sufficient severity to require treatment arises in two of every 1,000 pregnancies. It increases the risk of premature delivery. The fetus may develop goiter and transient hyperthyroidism. In treatment of pregnant women radioiodides are clearly contraindicated. They may cause huge fetal goiters. Antithyroid drugs may cross the placenta and cause cretinism. Propylthiouracil should be used with caution and, if used at all, administered for only short periods. Partial thyroid resection is the treatment of choice.

Hypothyroidism is a less frequent complication of pregnancy. If the mother is on thyroid medication at the time of conception, the usual dose should be maintained throughout pregnancy.

We are all familiar with the transient glycosuria of pregnant women. This usually clears up after delivery. Among those with gestational diabetes 20 to 30% will develop non-gestational diabetes in the following decade if they did not have it already. Among women with true diabetes whose hyperglycemia is not carefully controlled during pregnancy there is a definite risk of fetal abnormalities. These include congenital malformations, macrosomia, hydramnios with premature labor, sudden unexplained fetal death, fetal hypoxia, respiratory distress syndrome and neonatal hypoglycemia. These can be greatly minimized by diligent application of currently available obstetrical and medical procedures.

This inexpensive book covers all phases of metabolic disease in a way that is understandable for practicing physicians. It is highly recommended.

Paul S. Rhoads, M.D.
Richmond
Internal Medicine

Williams & Wilkins announces Aesthetic Breast Surgery, edited by Nicholas G. Georgiade, M.D., of the Plastic Surgery Division, Duke University Medical Center. Each method is described and illustrated and supplemented with references. More than 25 contributors describe surgical treatment of physical abnormalities of the female breast. 408 pages, 474 illustrations, \$69.95.

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# An added complication... in the treatment of bacterial bronchitis\*



### Brief Summary Consult the package literature for prescribing

Brief Summary Consult the package interature for prescribing information indications and Usage Cector\* (cefactor Lilly) is indicated in the treatment of the following infections when caused by susceptible interations and the following infections when caused by susceptible in the consumer of the consum

CLASSES Anthonics including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs. Pseudomembianous colitis has been reported with virtually all proad spectrum antibiotics including macrolodies semisynthetic penicilins, and cephalospoinist therefore, its important to consider its diagnosis in patients who develop diarrive an insspiciation with the use of antibiotics. Such colitis may range in severity from mild to after threatening.

broad-spectrum anabiotics including maciolides semisynthetic peniculins and cephalosporins therefore it is important to consider is diagnosis in patients who develop diautineal in association with the object of the property of the propert

Internal, with a history of gastrointestinal disease, particularly for the control of the contro

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Ceclor. 1-6

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus <u>pneumoniae</u>, <u>H. influenzae</u>, <u>S. pyogenes</u> (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.7



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with Gector are uncommon and are insted below 
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I in SO patients) and gential pruritus or vaginitis "less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical tabolatory retresults have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepalic—Sight elevations of SGDT. SGPT or alkaline phosphalase values (1 in 40).

Hematopoetic—Transient fluctuations in feukocyte count predominantly lymphocytosis occur ing in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serium creatinine rifess than 1 in Renal—Slight elevations in BUN or serium creatinine rifess than 1 in

Renal—Slight elevations in 8UN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

-Many authorities attribute acute infectious exacerbation of chromo bronchits to either S. preumonae of H. influenzae. \*
Note: Cection scontraindicated in patients with shown alleigy to the cephalospoinis and should be given cautiously to penicillin alleigic patients.

Penicillin is the usual drug of choice in the treatment and prevention of steptococcal infections, including the prophylaxis of rheumatic "ever. See prescribing information."

- cheumatic rever. See prescribing information
  References

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# **Aspiration Biopsy Cytology**

# CONTINUED FROM PAGES 595-599

- 1. Aspiration Biopsy Cytology is able to differentiate between:
  - a. Reactive lymphadenopathy and lymphoma
  - b. Lymphoma and metastatic carcinomac. Hodgkins disease and non-Hodgkins
  - Hodgkins disease and non-Hodgkins lymphoma
  - d. All of the above
- 2. All of the following are generally true of ABC *except*:
  - a. More aspiration samplings = reduced sampling error
  - b. More experienced aspirator = reduced sampling error
  - c. Larger gauge needle = better quality sample
  - d. Smaller syringe = reduced aspiration pressure for less hemorrhage
- 3. Rapid analysis in ABC allows:
  - a. Adequacy determination
  - b. Special processing
  - c. Information for further patient testing
  - d. All of the above
- 4. Thyroid ABC has the following advantages *except*:
  - a. Reduces thyroidectomy by 70%

- b. Diagnoses most malignant processes preoperatively
- c. Differentiates follicular adenoma from well differentiated follicular carcinoma
- d. Eliminates need for ultrasound and thyroid scan in most cases
- 5. Deep abdominal ABC is:
  - a. Usually radiologically guided
  - b. Is almost without complication
  - c. Can be done as an outpatient procedure with a post-biopsy observation period
  - d. All of the above
- 6. Diagnostic ABC can achieve all of the following *except*:
  - a. Malignant diagnoses equal to surgical biopsy
  - b. Benign diagnoses that can be reliably followed if clinical findings correlate
  - c. An elimination of false-negative cases
  - d. Procurement of material for special studies (microbiology, electron microscopy, immunohistochemistry, etc.)
- 7. Complications of ABC include all of the following *except*:

- a. Pneumothorax (10-20%) in intrathoracic sampling
- b. Hematoma (minor) in about 5% of superficial aspirations
- c. Needle track seeding of malignancy
- d. Minor tenderness in biopsy site for 24-48 hours
- 8. Limitations of ABC include all of the following *except*:
  - a. Fibrous lesions (fibrosis, fibrous neoplasm, or desmoplastic stroma in carcinoma) may cause a scantly cellular sample
  - b. Benign lesions may produce scantly cellular samples
  - Non-palpable (deep) or vaguely palpable lesions may require radiology guidance
  - d. Prostatic or transvaginal lesions can not be sampled
- 9. It is optimal if ABC diagnoses are reported:
  - a. By the Papanicolaou class system
  - b. As positive, suspicious, or negative
  - c. Similar to a surgical biopsy with follow-up recommendations in less than diagnostic cases
  - d. As "inadequate" if no malignancy is found
- 10. ABC is useful in the evaluation of a breast mass because:
  - a. Mammography may have a 20% false
  - "suspicious" rate
    b. Small lesions in a large breast are easy
  - to sample by palpation c. Abundant fat in the breast aids in
  - specimen aspiration
  - d. All of the above

# JULY CME QUIZ Answers

Following are the answers to the CME quiz that appeared in the July 1984 issue: "Evaluation of Short Stature in Children and Adolescents," by James C. Wright, M.D.

1. d 6. b
2. b 7. a
3. c 8. c
4. b 9. c
5. c 10. d

Answer sheet for Quiz: (Aspiration Biopsy Cytology)

 1. a b c d
 6. a b c d

 2. a b c d
 7. a b c d

 3. a b c d
 8. a b c d

 4. a b c d
 9. a b c d

 5. a b c d
 10. a b c d

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of Indiana Medicine for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for this month's quiz, send your completed, signed application before Sept. 10, 1984 to the address appearing at the top of this page.

# Standards of Professional Conduct and Competent Practice of Medicine

Since the Medical Licensing Board Rules regarding "Standards of Professional Conduct and Competent Practice of Medicine" were first proposed well over a year and a half ago, numerous changes have been made as a result of comments submitted by the Indiana State Medical Association, the Marion County Medical Society, the Vanderburgh County Medical Society and the Indiana State Medical Association's Physician Impairment Commission. ISMA was successful in modifying the definition of incompetence to include "a pattern or course of repeated conduct." It was the feeling of ISMA that this language needed to be incorporated into the definition since anyone is capable of committing a negligent act without being "professionally incompetent."

With the help of Larry M. Davis, M.D., chairman of the ISMA Commission on Physician Impairment, ISMA has been successful in changing the Rules to allow the management and treatment of an impaired physician by a duly authorized impaired or peer review committee without the committee being required to report to the Medical Licensing Board so long as the individual's efforts continue and his progress is satisfactory. This avenue provided by the Medical Licensing Board at ISMA's request will require that Indiana county medical societies and hospitals establish and maintain impaired physician committees and peer review committees at a functional level in order to offer this preferable route to that of direct reporting to the Medical Licensing Board.

The new Rules relating to excessive fees have been modified from that originally proposed by the Board and now conform with language that appears in the *Current Opinions of the Judicial Council of the American Medical Association*.

SECTION 6. 844 IAC 5 is added to read as follows.

# ARTICLE 5. STANDARDS OF PROFESSIONAL CON-DUCT AND COMPETENT PRACTICE OF MEDICINE

Rule 1. Definitions

### 844 IAC 5-1-1 Definitions

Authority: IC 25-22.5-2-7

Affected: IC 25-10; IC 25-13; IC 25-14; IC 25-20; IC 25-22.5; IC 25-23; IC 25-24; IC 25-26; IC 25-27; IC 25-29; IC 25-33; IC 25-35.6; IC 35-48-1; IC 35-48-2

- Sec. I. For purposes of the standards of professional conduct and competent practice of medicine, the following definitions apply: (a) "Professional incompetence" may include, but is not limited to, a pattern or course of repeated conduct by a practitioner demonstrating a failure to exercise such reasonable care and diligence as is ordinarily exercised by practitioners in the same or similar circumstances in the same or similar locality.
- (b) "Practitioner" means a person who holds an unlimited license to practice medicine or osteopathic medicine in Indiana or a limited license or permit as may be issued by the board.
- (c) "Specific professional health care provider" means any person who holds a specific license to practice in an area of health care in Indiana, including, but not limited to, the following persons:
  - (1) any chiropractor licensed under IC 25-10;
  - (2) any dental hygienist licensed under IC 25-13;
  - (3) any dentist licensed under IC 25-14;
  - (4) any hearing aid dealer licensed under IC 25-20;
  - (5) any nurse licensed under IC 25-23;
  - (6) any optometrist licensed under IC 25-24;
  - (7) any pharmacist licensed under IC 25-26;
  - (8) any physical therapist licensed under IC 25-27;
- (9) any podiatrist licensed under 1C 25-29;
- (10) any psychologist licensed under IC 25-33;
- (11) any speech pathologist or audiologist licensed under IC 25-35.6.
- (d) For purposes of clarifying the terminology used in IC 25-22.5-6-2.1(b)(7), and for purposes of the standards of professional conduct and competent practice of medicine, the following definitions apply:
  - (1) "Addict" means a person who is physiologically and/or psychologically dependent upon a drug which is classified as a narcotic, controlled substance or dangerous drug.
  - (2) "Habitue" means a person who is physiologically and/or

psychologically dependent upon any narcotic, drug classified as a narcotic, dangerous drug or controlled substance under Indiana law; or a person who consumes on a regular basis, and without any medically justifiable purpose, a narcotic drug classified as a narcotic, dangerous drug or controlled substance under Indiana law, whether or not such person has developed a physiological or psychological dependence upon such substance.

- (3) "Classified as a narcotic" means any substance which is designated as a controlled substance under 1C 35-48-1, or 1C 35-48-2, or so classified in any subsequent amendment or revision of said statutes.
- (4) "Dangerous drug" means any substance which is designated as a controlled substance under IC 35-48-1, or IC 35-48-2, or so classified in any subsequent amendment or revision of said statute.

(Medical Licensing Board of Indiana; 844 IAC 5-1-1; filed Apr 12, 1984, 8:28 am)

### 844 IAC 5-1-2 Standards of professional conduct

Authority: 1C 25-22.5-2-7

Affected: IC 16-4-8; IC 25-22.5-1-1; IC 25-22.5-6-2.1; IC 34-4-12.6-1

- Sec. 2. A practitioner in the conduct of his/her practice of medicine or osteopathic medicine shall abide by, and comply with, the following standards of professional conduct; (a) A practitioner shall maintain the confidentiality of all knowledge and information regarding a patient, including, but not limited to, the patient's diagnosis, treatment and prognosis, and of all records relating thereto, about which the practitioner may learn or otherwise be informed during the course of, or as a result of, the patient-practitioner relationship. Information about a patient shall be disclosed by a practitioner when required by law, including, but not limited to, the requirements of 1C 34-4-12.6-1 and of 1C 16-4-8-1, and any amendments thereto, or when authorized by the patient or those responsible for the patient's care.
- (b) A practitioner shall give a truthful, candid and reasonably complete account of the patient's condition to the patient or to those responsible for the patient's care, except where a practitioner reasonably determines that the information is or would be detrimental to the physical or mental health of the patient, or in the case of a minor or incompetent person, except where a practitioner reasonably determines that the information is or would be detrimental to the physical or mental health of those persons responsible for the patient's care.
- (c) The practitioner shall give reasonable written notice to a patient or to those responsible for the patient's care when the practitioner withdraws from a case so that another practitioner may be employed by the patient or by those responsible for the patient's care. A practitioner shall not abandon a patient.

A practitioner who withdraws from a case, except in emergency circumstances, shall, upon written request, and in conformity with the provisions of 1C 16-4-8-1 through 1C 16-4-8-11,

and of any subsequent amendment or revision thereof, make available to his/her patient or to those responsible for the patient's care, and to any other practitioner or specific professional health care provider employed by the patient, or by those responsible for the patient's care, all records, test results, histories, x-rays, radiographic studies, diagnoses, files and information relating to said patient which are in the practitioner's custody, possession or control, or copies of such documents herein-before described.

- (d) A practitioner shall exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice.
- (e) A practitioner shall not represent, advertise, state or indicate the possession of any degree recognized as the basis for licensure to practice medicine or osteopathic medicine unless the practitioner is actually licensed on the basis of such degree in the state(s) in which he/she practices.
- (f) A practitioner shall make reasonable efforts to obtain consultation whenever requested to do so by a patient or by those responsible for a patient's care. Further, the practitioner shall refer a patient to another practitioner in any case where the referring practitioner does not consider himself/herself qualified to treat the patient, and may refer the patient to another practitioner where the referring practitioner is unable to diagnose the illness or disease of the patient.
- (g)(1) A practitioner who has personal knowledge based upon a reasonable belief that another practitioner holding the same licenses has engaged in illegal, unlawful, incompetent or fraudulent conduct in the practice of medicine or osteopathic medicine shall promptly report such conduct to a peer review or similar body, as defined in IC 34-4-12.6-1(c), having jurisdiction over the offending practitioner and the matter. This provision does not prohibit a practitioner from promptly reporting said conduct directly to the medical licensing board. Further, a practitioner who has personal knowledge of any person engaged in, or attempting to engage in, the unauthorized practice of medicine or osteopathic medicine shall promptly report such conduct to the medical licensing board.
- (2) A practitioner who voluntarily submits himself/herself to, or is otherwise undergoing a course of treatment for, addiction, severe dependency upon alcohol or other drugs or controlled substances, or for psychiatric impairment, where such treatment is sponsored or supervised by an impaired physicians committee of a state, regional or local organization of professional health care providers, or where such treatment is sponsored or supervised by an impaired physicians committee of a hospital, shall be exempt from reporting to a peer review committee as set forth in subsection (g)(1) or to the medical licensing board for so long as:
  - (A) the practitioner is complying with the course of treatment;

- (B) the practitioner is making satisfactory progress.
- If the practitioner fails to comply with, or is not benefitted by, the course of treatment, the practitioner-chief administrative officer, his designee, or any member of, the impaired physicians committee shall promptly report such facts and circumstances to the medical licensing board. This subsection shall not, in any manner whatsoever, directly or indirectly, be deemed or construed to prohibit, restrict, limit or otherwise preclude the medical licensing board from taking such action as it deems appropriate or as may otherwise be provided by law.
- (h)(1) Fees charged by a practitioner for his/her professional services shall be reasonable and shall reasonable [sic.] compensate the practitioner only for services actually rendered.
- (2) A practitioner shall not enter into agreement for, charge, or collect an illegal or clearly excessive fee.
- (3) Factors to be considered in determining the reasonableness of a fee include, but are not limited to, the following:
  - (A) the difficulty and/or uniqueness of the services performed and the time, skill and experience required;
  - (B) the fee customarily charged in the locality for similar practitioner services;
  - (C) the amount of the charges involved;
  - (D) the quality of performance;
  - (E) the nature and length of the professional relationship with the patient; and
  - (F) the experience, reputation and ability of the practitioner in performing the kind of services involved.
- (i) A practitioner shall not divide a fee for professional services with another practitioner who is not a partner, employee, or shareholder in a professional corporation, unless:
  - (1) the patient consents to the employment of the other practitioner after a full disclosure that a division of fees will be made; and
  - (2) the division of fees is made in proportion to actual services performed and responsibility assumed by each practitioner.
- (j) A practitioner shall not pay, demand, or receive compensation, for referral of a patient, except for a patient referral program operated by a medical society or association which is approved by the medical licensing board.
- (k) A practitioner shall be responsible for the conduct of each and every person employed by the practitioner (whether such employee is a physician, nurse, physician's assistant, or other specific professional health care provider employed by the practitioner) for every action or failure to act by said employee or employees in the course of said employee(s) employment relationship with said practitioner; provided, however, that a practitioner shall not be responsible for the actions of persons he/she may employ whose employment by the practitioner [sic.] does not relate directly to the practitioner's practice of medicine or of osteopathic medicine.

- (l)(1) A practitioner shall not, on behalf of himself/herself, a partner, associate, shareholder in a professional corporation, or any other practitioner or specific health care provider affiliated with the practitioner, use, or participate in the use of, any form of public communication containing a false, fraudulent, misleading, deceptive or unfair statement or claim.
- (2) Subject to the requirements of subsection (l)(1) of this section, and in order to facilitate the process of informed selection of a practitioner by the public, a practitioner may advertise services through the public media including, but not limited to, a telephone directory, physicians' or osteopaths' directory, newspaper or other periodical, radio or television or through written communication not involving personal contact, provided that the advertisement is dignified and confines itself to the existence, scope, nature and field of practice of the practitioner.
- (3) If the advertisement is communicated to the public by radio, cable, or television, it shall be prerecorded, approved for broadcast by the practitioner, and a recording and transcript of the actual transmission shall be retained by the practitioner for a period of five (5) years from the last date of broadcast.
- (4) If a practitioner advertises a fee for a service, treatment, consultation, examination, radiographic study, or other procedure, the practitioner must render that service or procedure for no more than the fee advertised.
- (5) Unless otherwise specified in the advertisement, if a practitioner publishes or communicates any fee information in a publication that is published more frequently than one (1) time per month, the practitioner shall be bound by any representation made therein for a period of thirty (30) days after the publication date. If a practitioner publishes or communicates any fee information in a publication that is published once a month or less frequently, the practitioner shall be bound by any representation made therein until the publication of the succeeding issue. If a practitioner publishes or communicates any fee information in a publication which has no fixed date for publication of a succeeding issue, the practitioner shall be bound by any representation made therein for one (1) year.
- (6) Unless otherwise specified, if a practitioner broadcasts any fee information by radio, cable or television, the practitioner shall be bound by any representation made therein for a period of ninety (90) days after such broadcast.
- (7) Except as otherwise specified in 844 IAC 5, a practitioner shall not contact or solicit individual members of the public personally or through an agent in order to offer services to such person or persons unless that individual initiated contact with the practitioner for the purpose of engaging that practitioner's professional services.
- (m) A practitioner may, whenever the practitioner believes it to be beneficial to the patient, send or refer a patient to a qualified specific professional health care provider for treatment or health care which fall within the specific professional

health care provider's scope of practice. Prior to any such referral, however, the practitioner shall examine, and/or consult with, the patient to insure that a condition exists in the patient which would be within the scope of practice of the specific professional health care provider to whom the patient is referred or sent.

- (n) A practitioner shall not charge a separate and distict [sic.] fee for the incidental, administrative, non-medical service of securing admission of a patient to a hospital or other medical or health care facility.
- (o)(1) A practitioner, upon his/her retirement, or upon discontinuation of the practice of medicine or osteopathic medicine, or upon leaving or moving from a community, shall not sell, convey or transfer for valuable consideration, remuneration or for anything of value, patient records of that practitioner to any other practitioner.
- (2) A practitioner, upon his/her retirement, or upon discontinuation of the practice of medicine or osteopathic medicine, or upon leaving or moving from a community, shall notify all of his/her patients in writing, or by publication once a week for three (3) consecutive weeks in a newspaper of general circulation in the community, that he/she intends to discontinue his/her practice of medicine or osteopathic medicine in the community, and shall encourage his/her patients to seek the services of another practitioner, provided, however, that this subsection shall not apply to practitioners solely engaged in internship, residency, preceptorship, fellowship, teaching or other postgraduate medical education or training programs. The practitioner discontinuing his/her practice shall make reasonable arrangements with his/her active patients for the transfer of his/her records, or copies thereof, to the succeeding practitioner, or to a program conducted by a medical society or association approved by the medical licensing board.
- (3) As used herein, "active patient" applies and refers to a person whom the practitioner has examined, treated, cared for, or otherwise consulted with, during the two (2) year period prior to retirement, discontinuation of the practice of medicine or osteopathic medicine, or leaving or moving from a community.
- (4) Nothing herein provided shall preclude, prohibit or prevent a practitioner from conveying or transferring the practitioner's patient records to another practitioner, holding an unlimited license to practice medicine or osteopathic medicine, who is assuming a practice, provided that written notice is furnished to all patients as hereinbefore specified.
- (p) A practitioner shall not base his fee upon the uncertain outcome of a contingency, whether such contingency be the outcome of litigation or any other occurrence or condition which may or may not develop, occur or happen.
- (q) A practitioner shall not attempt to exonerate himself from or limit his liability to a patient for his/her personal malprac-

tice except that a practitioner may enter into agreements which contain informed, voluntary releases and/or waivers of liability in settlement of a claim made by a patient or by those responsible for a patient's care.

(r) A practitioner shall not attempt to preclude, prohibit or otherwise prevent the filing of a complaint against him/her by a patient or other practitioner for any alleged violation of 844 IAC or of any alleged violation of IC 25-22.5-1.1, or of any other law. (Medical Licensing Board of Indiana; 844 IAC 5-1-2; filed Apr 12, 1984, 8:28 am)

# 844 IAC 5-1-3 Disciplinary action

Authority: IC 25-22.5-2-7 Affected: IC 25-22.5-2-7

Sec. 3. Failure to comply with the above standards of professional conduct and competent practice of medicine may result in disciplinary proceedings against the offending practitioner. Further, all practitioners licensed in Indiana shall be responsible for having knowledge of the standards of conduct and practice established by statute and regulation pursuant to IC 25-22.5-2-7. (Medical Licensing Board of Indiana; 844 IAC 5-1-3; filed Apr 12, 1984, 8:28 am)

SECTION 7. 844 IAC 7 is added to read as follows:

### ARTICLE 7. RULES FOR REINSTATEMENT

Rule 1. General Provisions

# 844 IAC 7-1-1 Reinstatement

Authority: IC 25-22.5-2-7; IC 25-22.5-6-2.1 Affected: IC 25-22.5; IC 25-27; IC 25-29; IC 25-33

- Sec. 1. No person whose license to practice medicine or osteopathic medicine, midwifery, or whose license as a podiatrist, physical therapist, physical therapist assistant, or whose registration and approval as a physician's assistant, has been suspended or revoked shall be eligible for reinstatement unless that person establishes by clear and convincing evidence before the medical licensing board that:
  - (1) the person desires in good faith to obtain restoration of such license, registration or approval;
  - (2) the term of suspension prescribed in the order of suspension has elapsed or seven (7) years have elapsed since the revocation;
  - (3) the person has not engaged in that practice for which that person was licensed, registered or approved, in this state or has attempted to do so from the date discipline was imposed;
  - (4) the person has complied fully with the terms, if any, of the order for suspension or revocation;
  - (5) the person's attitude with regard to the misconduct, violation of law or rule, or incompetent practice for which the person was disciplined is one of genuine remorse;
  - (6) the person has a proper understanding of an attitude towards the standards that are imposed by statute or rule upon persons holding such license, registration or approval

as had been suspended or revoked and the person can be reasonably expected to conduct himself/herself in conformity with such standards;

- (7) the person can be safely recommended to the public and applicable professions as a person fit to be reinstated and is able to practice his/her profession with reasonable skill and safety to patients;
- (8) the disability has been removed, corrected or otherwise brought under control if the suspension or revocation was imposed by reason of physical or mental illness or infirmity, or for use of or addiction to intoxicants or drugs;
- (9) the person has successfully taken and completed such written examinations and tests as may be required by the medical licensing board, and has completed such professional training or education under a preceptorship as may be required. (Medical Licensing Board of Indiana; 844 IAC 7-1-1; filed Apr 12, 1984, 8:28 am)

### 844 IAC 7-1-2 Petitions for reinstatement

Authority: 1C 25-22.5-2-7; 1C 25-22.5-6-2.1 Affected: 1C 25-22.5; 1C 25-27; 1C 25-29; 1C 25-33

Sec. 2. Any person whose license, registration or approval has been suspended or revoked may apply for reinstatement by filing with the medical licensing board a petition setting forth that the requirements of 844 1AC 7-1-1 have been satisfied or complied with. Ten (10) copies of such petition shall be filed with the medical licensing board, together with a filing fee of four hundred dollars \$(400).

Upon the filing of such petition and payment of the filing fee, the medical licensing board shall schedule a hearing. After the hearing the medical licensing board shall determine whether the petitioner has met the requirements set forth in 844 IAC 7-1-1, and shall determine whether, as a condition of reinstatement, disciplinary or corrective measures, including, but not limited to, reexamination, additional training or post-graduate education, or a preceptorship, should be imposed. The medical licensing board shall thereafter, upon satisfactory compliance with the requirements of 844 IAC 7-1-1 and of any and all disciplinary and corrective measures which may be imposed, enter an order continuing the suspension or revocation or reinstating a license, registration or approval to the petitioner.

Any person filing for reinstatement shall be responsible for the payment of any and all costs incurred by the medical licensing board in conducting a hearing upon said petition for reinstatement which exceed the amount of the filing fee. Any such costs shall be paid by the petitioner within fifteen (15) days of the receipt of a statement therefor from the medical licensing board. In no event will there be any refund or rebate of any part of the filing fee.

In the event that a person is unable to pay the filing fee or costs or to give security therefor, the person shall file ten (10) copies of a verified motion requesting waiver of the prepayment of such fees and costs accompanied by an affidavit executed on the person's personal knowledge stating that such

person is unable to pay such fees and costs or to give security therefor. The affidavit shall be in the following form:

# BEFORE THE MEDICAL LICENSING BOARD

IN THE MATTER OF:

Affidavit in Support of Motion to Proceed Without Prepayment of Fees and Costs

I,\_\_\_\_\_\_\_, being first duly sworn, depose and say that I am the petitioner in the above-entitled cases; that in support of my motion to proceed without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; that I believe I am entitled to redress; and that the issues which I desire to present are the following:

### (LIST ISSUES)

I further swear and affirm that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of prosecuting the case are true.

- 1. Are you presently employed?
  - a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.
  - b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received.
- 2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?
  - a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.
- 3. Do you own any cash or checking or savings account?
  - a. If the answer is yes, state the total value of the items owned.
- 4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?
  - a. If the answer is yes, describe the property and state its approximate value.
- 5. List the persons who are dependent upon you for support and state you [*sic.*] relationship to those persons.

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

(SIGN NAME)	
SUBSCRIBED AND SWORN TO before me t	his
day of,	19

The medical licensing board may conduct such investigations and hearings as it may deem appropriate and necessary in ruling upon motions requesting waiver of the prepayment of fees and costs. Although prepayment of fees and costs may be waived by the medical licensing board, the petitioner shall remain responsible for the payment of fees and costs which payment may be a condition of reinstatement. (Medical Licensing Board of Indiana; 844 IAC 7-1-2; filed Apr 12, 1984, 8:28 am)

# 844 IAC 7-1-3 Duties of revoked licensees and registrants

Authority: IC 25-22.5-2-7; IC 25-22.5-6-2.1

Affected: IC 25-22.5; IC 25-27; IC 25-29; IC 25-33

- Sec. 3. In any case where a person's license, registration or approval has been revoked, said person shall:
  - (1) Promptly notify or cause to be notified by in the manner and method specified by the board, all patients then in the care of the licensee or registrant, or those persons responsible for the patient's care, of the revocation and of the licensee's or registrant's consequent inability to act for or on their behalf in the licensee's or registrant's professional capacity. Such notice shall advise all such patients to seek the services of another licensee in good standing of their own choice
  - (2) Promptly notify or cause to be notified all hospitals, medical and health care facilities where such licensee or registrant has privileges or staff status of the revocation accompanied by a list of all patients then in the care of said licensee or registrant.
  - (3) Notify in writing, by first class mail, the following organizations and governmental agencies of the revocation of licensure, registration or approval:
    - (A) Indiana department of public welfare;
    - (B) Social Security Administration;
    - (C) the medical licensing board(s), or equivalent state agency, of each state in which the person is licensed, registered or approved;
    - (D) drug enforcement administration;
    - (E) Indiana hospital association;
    - (F) Indiana state medical association;
    - (G) Indiana pharmacists association;
    - (H) American Medical Association;
    - (I) American Osteopathic Association;
    - (J) Federation of State Medical Boards of the United States, Inc.
  - (4) Make reasonable arrangements with said licensee's or registrant's active patients for the transfer of all patient records, radiographic studies, and test results, or copies thereof, to a succeeding licensee or registrant employed by the patient or by those responsible for the patient's care.
  - (5) Within thirty (30) days after the date of license or registration revocation, the licensee or registrant shall file an affidavit with the medical licensing board showing compliance with

the provisions of the revocation order and with 844 IAC 7 which time may be extended by the board. Such affidavit shall also state all other jurisdictions in which the licensee or registrant is still licensed and/or registered.

(6) Proof of compliance with this section shall be a condition precedent to any petition for reinstatement.

(Medical Licensing Board of Indiana; 844 IAC 7-1-3; filed Apr 12, 1984, 8:28 am)

# 844 IAC 7-1-4 Duties of suspended licensees and registrants Authority: IC 25-22.5-2-7; IC 25-22.5-6-2.1

Affected: IC 25-22.5; IC 25-27; IC 25-29; IC 25-33

- Sec. 4. In any case where a person's license or registration has been suspended, said person shall:
- (1) Within thirty (30) days from the date of the order of suspension, file with the medical licensing board an affidavit showing that:
  - (A) All active patients then under the licensee's or registrant's care have been notified in the manner and method specified by the board of the licensee's or registrant's suspension and consequent inability to act for or on their behalf in a professional capacity. Such notice shall advise all such patients to seek the services of another licensee or registrant of good standing of their own choice.
  - (B) All hospitals, medical and health care facilities where such licensee or registrant has privileges or staff status have been informed of the suspension order.
  - (C) Reasonable arrangements were made for the transfer of patient records, radiographic studies, and test results, or copies thereof, to a succeeding licensee or registrant employed by the patient or those responsible for the patient's care.
- (2) Proof of compliance with this section shall be a condition precedent to reinstatement.

(Medical Licensing Board of Indiana; 844 IAC 7-1-4; filed Apr 12, 1984, 8:28 am)

# 844 IAC 7-1-5 Protection of patient's interest

Authority: IC 25-22.5-2-7; IC 25-22.5-6-2.1

Affected: IC 25-22.5; IC 25-27; IC 25-29; IC 25-33

Sec. 5. Whenever a person's license or registration has been revoked or suspended, and said person has not fully complied with the provisions of 844 IAC 7-1-3 and 844 IAC 7-1-4, or if said licensee or registrant has disappeared or died or is otherwise unable to comply with said sections, the medical licensing board shall request the health professions service bureau or any state medical or osteopathic association or any county medical or osteopathic society to take such action as may be appropriate to protect the interests of that person's patients. (Medical Licensing Board of Indiana; 844 IAC 7-1-5; filed Apr 12, 1984, 8:28 am)

# NEWS NOTES.

# Here and There . . .

- . . . Dr. Carl E. Otten of Indianapolis discussed Premenstrual Syndrome during a June seminar sponsored by the Indianapolis PMS Support Group.
- . . . Dr. John C. Johnson of Crown Point has been reappointed by Governor Orr to the Emcrgency Medical Services Commission.
- ... **Dr. John J. Mulcahy**, director of urology at Wishard Memorial Hospital, Indianapolis, discussed male infertility at the June meeting of the Fort Wayne chapter of Indiana Resolve.
- ... Dr. R. I. Patel of Marion served as keynote speaker and medical advisor at a June seminar on "better breathing" sponsored by Marion General Hospital and the American Lung Association of Indiana.
- ... **Dr. Richard C. McNabb** of Martinsville is the new full-time medical director of the Otis R. Bowen Center for Human Services, Warsaw.
- ... **Dr. Frederick A. Tolle** has been named medical director of the Sleep Disorders Center, Winona Memorial Hospital, Indianapolis.
- ... Dr. Frank E. Young has been appointed commissioner of the Food and Drug Administration, replacing Dr. Arthur Hull Hayes, who resigned last fall.
- ... **Dr. Fred J. Harris** of Valparaiso discussed hypertension during a recent meeting sponsored by St. Anthony Hospital and the Michigan City Community Mended Hearts Club.
- . . . Dr. Ivan T. Lindgren of Aurora, a member of the Pennsylvania Air National Guard, has been promoted to colonel.
- ... **Dr. Maurice Kaufman** of Indianapolis has been elected first vice-president of the Central Indiana Council on Aging.
- ... **Dr. Mary G. Ludwig** of Crawfordsville has been appointed by Governor Orr to a four-year term on the Advisory Committee for Medical Assistance.
- ... Dr. Howard F. Polley of Bloomington discussed advances in rheumatology during the annual meeting of the American Rheumatism Association in Minneapolis.
- ... **Dr. Benvenido V. Ticsay** of Michigan City is the new president of the Philippine-American Urological Society.

- ... **Dr. William D. Province II** of Franklin addressed a recent meeting of the Johnson County Memorial Hospital's Respiratory Health Club.
- . . . Dr. John M. Thompson, a South Bend ophthalmologist, has been named Alumnus of the Year by Indiana Central University.
- ... **Dr. Everett W. Gaunt**, an Alexandria family physician, has retired from active practice although he has retained his post as county health officer.
- ... **Dr. James M. Donahue**, a Franklin psychiatrist, is the new president of the Johnson County Unit, American Cancer Society.
- Bend addressed arthritis patients at a recent public forum in Michigan City.
- ... Dr. Cherryl G. Friedman of Noblesville discussed heart disease and stress at a June meeting of Riverview Hospital's Cardiac Club.
- . . . **Dr. Jatinger Kansal** of Merrillville has been board-certified in allergy and clinical immunology.
- . . . **Dr. Shou-Gem Lin** of Merrillville has been board-certified in otorhinolaryngology.
- ... **Dr. Won-Shick Loh** of Munster and **Dr. Trent G. Orfanos** of Crown Point have been board-certified in internal medicine and cardiology.
- . . . Dr. George T. Lukemeyer, ISMA president, has received a distinguished medical alumni award from the I.U. School of Medicine, of which he is a 1947 graduate.
- ... Dr. Jill J. Blacharsh, a Bloomington psychiatrist, was among several speakers participating in a recent public forum dealing with mental illness; it was sponsored by the Marion County Mental Health Association and the South Central Community Mental Health Center
- has been appointed to Governor Orr's search and screen committee to select a new commissioner for the Indiana State Board of Health; **Dr. William J. Miller** of Lafayette is chairman.
- ... Dr. Randolph W. Lievertz of Indianapolis appeared on public television (Ch. 20) in June in an ISMA-sponsored "Heartbeat" episode on "Living with Stress."

- dianapolis discussed "Prognostic Significance of Positive Peritoneal Cytology in Patients with Endometrial Carcinoma" at a meeting of the Continental Gynecologic Society in Bermuda in June.
- ... Dr. David A. Josephson of Carmel is the new president of the Indiana Neurological Society.
- ... Dr. Stanley R. Adkins of Columbus was the keynote speaker at this year's annual meeting in Greensburg of the Southeast Indiana Division, American Heart Association.
- ... Dr. Primo A. Andres and Dr. Thomas F. Orman of Terre Haute have been certified by the American Board of Cardiology.
- ... Dr. Robert M. Hurwitz, an Indianapolis dermatologist, discussed the sun's effect on skin and basic skin care during a public forum in June at Humana Women's Hospital.
- has been elected president-elect of the medical staff at Winona Memorial Hospital, Indianapolis.
- ... Dr. Samuel M. Wentworth of Danville was a guest speaker at a June diabetes education workshop held at the Hulman Civic University Center, Terre Haute.
- ... Dr. Peter H. Cahn, an Indianapolis ophthalmologist, discussed "Laser Treatment of Glaucoma" during the annual Lester D. Bibler Family Practice Review Course, held June 21 in Indianapolis.

# **Iverson Takes Detroit Post**

Dr. Robert L. Iverson, co-director of the Department of Adult Critical Care at the Methodist Hospital, Indianapolis, since 1977, has accepted appointment as Assistant Professor of Medicine at Wayne State University School of Medicine, Detroit. He will work in the Division of Pulmonary/Critical Care in both teaching and research duties at Detroit Receiving Hospital and Harper Hospital at Detroit Medical Center.

Dr. Iverson has been instrumental in organizing and contributing to a series of special articles on critical care for INDIANA MEDICINE.

# Richter Lectureship

Dr. Joseph K. Perloff of Los Angeles will be the guest lecturer for the ninth annual Arthur B. Richter Lectureship in Clinical Cardiology on Wednesday, Sept. 12, at St. Vincent Hospital and Health Care Center, Indianapolis.

Dr. Perloff, Streisand professor of medicine and pediatrics at the University of California in Los Angeles, will discuss "The Cardiomyopathies: A Contemporary Overview," "Heart Disease in Pregnancy" and "Heart Disease: A Natural Occurrence or a Self-Imposed Affliction?" He will also discuss case studies presented by noted local physicians.

Dr. Perloff is a fellow of the American Heart Association's Council on Clinical Cardiology, the American College of Cardiology and the American College of Physicians. He is the author of several cardiology books.

There is no charge for the seminar. Reservations for dinner at the Meridian



Dr. Perloff

Hills Country Club after the seminar may be made by calling (317) 871-2161.

# Patients Needed for Study of New Diabetes Drug

Dr. Charles M. Clark of the Diabetes Research & Training Center, Indiana University School of Medicine, is recruiting patients for a study examining the beneficial effects of a new drug, Tolrestat, on symptomatic diabetic neuropathy.

Treatment for diabetic neuropathy is not very effective at present, Dr. Clark said. Tolrestat is a member of a new class of drugs, aldose-reductase inhibitors, which he said "theoretically should relieve the symptoms by interfering with the basic patho-physiologic process."

The study requires nine outpatient visits over a year. Patients between the ages of 18 and 72 who are otherwise in good health are eligible.

Dr. Clark asks that physicians who have patients with diabetes who might qualify for the study refer them to the Diabetes Research & Training Center by calling (317) 630-6374.



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# DEWS DOTES

# Mobile NMR Scanner

The world's first mobile nuclear magnetic resonance scanner (NMR) is now in operation in a truck trailer parked in front of Temple University Hospital.

The machine is called the Fonar BETA 3000M and is manufactured by the Fonar Corporation. Nearby street traffic, the nearby subway system and a heavy construction crane have not interfered with the proper operation of the scanner. Mobility of the unit allows it to function at other Philadelphia hospitals.

# **Aviation Medicine Award**

Dr. James Waggoner, medical director of The Garrett Corporation, Los Angeles, has received the Airlines Medical Directors Association award for "outstanding contribution to aviation medicine."

The award is not an annual affair but, in this instance, was given as a special recognition of the many contributions to aviation medicine by Dr. Waggoner, who is a 1949 graduate of I.U. School of Medicine.

# AMA-ERF Grant

The AMA Education and Research Foundation has announced its annual grants to approved medical schools in the United States and Canada. Indiana University School of Medicine received \$74,415.89.

The grants are made from funds contributed during 1983 and are given to benefit medical schools and medical student assistance programs at the schools.

# Physician Recognition Awards —



The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.



Adye, Wallace M., Evansville Agana, Adriano A., Gary Ahler, Kenneth J., Rensselaer Akrabawi, Salim S., Evansville Angeles, Armando E., Connersville Ayers, Johnnie, Kokomo Babcoke, Gary A., Chesterton Baker, Glenn W., Brownsburg Baxter, Harry R., Seymour Bhagwandin, Harry O., Indianapolis Billena, Raymundo L., Merrillville Blaisdell, William F., Seymour Bloom, George R., Elkhart Boaz, William D., Wabash Bobb, Kenneth E., Seymour Branco, Arthur M., Munster Calisto, Ruben A., Logansport Carey, John A., Gary Castueras, Flor T., Salem Clutter, Robert E., Indianapolis Cole, Larry G., Yorktown Connelly, Richard D., Fort Wayne Cortese, Thomas A., Indianapolis Crebo, Alan R., Kokomo Daftary, Mostafa, Greensburg Davis, Timothy E., Elkhart Deitsch, Howard C., Richmond Drake, James R., Anderson Edwards, William A., Danville Felker, Dean R., Greenfield Flamion, Patrick C., Evansville

Fogle, Norman L., Indianapolis Furr, Jack D., Hillsboro Galbreath, Richard E., Warsaw Gillum, Eugene M., Portland Glassley, Stephen H., Fort Wayne Greene, Morgan E., Indianapolis Guebard, Bruce A., Fort Wayne Gupta, Ram C., Merrillville Hadley, David M., Plainfield Haines, David W., Warsaw Hardin, Stephen L., Martinsville Harris, C.G., South Bend Hathaway, William H., Auburn Hennessee, Samuel D., Carmel Hollenberg, Edward L., Winamac Holwerda, Harry L., Demotte Hull, Joel I., Chesterton Jani, Natwerlal S., Indianapolis Julius, Satish C., Evansville Kaye, Robert C., Rensselaer Kincaid, Richard W., Evansville Kobak, Alfred J., Valparaiso La Salle, Robert M., Wabash Lee, John W., Fort Wayne Leipold, Jon D., South Bend Lewis, Merral B., Evansville Luxenberg, Edwin R., Logansport Mattox, Dean L., LaGrange McCalla, Charles X. III, Paoli McClary, Charles W., Bloomington McClure, Warren N., Kokomo

Meissel, Robert L., Terre Haute Miller, Donald C., Cedar Lake Miller, William J., Lafayette Mishkin, Marvin E., Elkhart O'Brian, Earl J., Indianapolis Price, Francis W., Indianapolis Richmond, Harold W., Columbus Rigaux, Armand J., South Bend Roth, Bertram S., Indianapolis Shelley, Edward S., South Bend Skiles, Melvin J., Madison Smith, Philip L., Fort Wayne Sondgerath, Clifford J., Lafayette Stouder, Gary S., Greenfield Stucky, Jerry L., Fort Wayne Sturdevant, Frank M., Valparaiso Tanner, Richard R., Indianapolis Thomas, Charles R., Indianapolis Thompson, William R., Winamac Tirman, Wallace S., Plymouth Torrella, Roxann M., Indianapolis Valentine, Russell P., Zionsville Valenzuela, Roberto D., Merrillville Van Tassel, Charles J., Indianapolis Voskuhl, William L., Charlestown Waflart, Theodore A., Huntingburg Wagner, Richard A., Evansville Webb, Harry D., Anderson Wooten, William G., Evansville Zawadsky, Sarette C., West Lafayette Zink Robert O., Madison

# Where to Look for Nutrition Information

Accuracy of nutrition information in magazines is monitored by the American Council on Science and Health (ACSH). The most recent such survey involved 30 popular magazines, nine of which were found to contain nutrition information of high accuracy rating.

The nine magazines are Good Housekeeping, Self, Health, Essence, Glamour, Vogue, American Health, Mademoiselle, and Consumers' Research. All members of this group were observed to publish nutritional news frequently.

Eleven other magazines, which publish articles on nutrition less frequently, also earned high ratings. They are Better Homes and Gardens, Changing Times, 50 Plus, Parents, Reader's Digest, Redbook, Science '82-'83, Scientific American, Seventeen, Consumer Reports, and Consumers' Digest.

Several other magazines received ratings of low accuracy, although two of

this group identify themselves as health-oriented.

Copies of ACSH NEWS & VIEWS may be obtained from ACSH, 47 Maple St., Summit, N.J. 07901.

# **EDB Ban Opposed**

The American Council on Science and Health has published a 27-page report on Eythlene Dibromide (EDB), a copy of which may be obtained for \$2 by writing the council at 1995 Broadway, New York, N.Y. 10023.

The council position statement appears in the booklet as follows: "ACSH strongly agrees with EPA's setting of tolerance levels for EDB in consumer foods (these were long overdue) but believes that the complete ban on the grain-related uses of EDB and the impending ban for its uses on fruit are serious mistakes. Therefore, ACSH recommends that the ban on grain-related uses of EDB be lifted and the proposed ban on the use of EDB in the fumigation of fruit be postponed un-

til and unless a suitable replacement is found."

The following quotation introduces the discussion: "Calculation of pepper's carcinogenic potency shows that at the daily dose humans ingest, (140 mg), they are exposed to some 10 to 100 times the carcinogenic risk than from EDB residues in food."

# **NIH Conferences Slated**

The National Institutes of Health have announced plans to conduct two consensus development conferences in the near future.

"Indications for and Risks of Treatment with Fresh Frozen Plasma" will be discussed Sept. 24-26, and "Limb-Sparing Treatment of Adult Soft-Tissue and Osteogenic Sarcomas" will be discussed Dec. 3-5.

Both meetings will be held at the Masur Auditorium, National Institutes of Health, Bethesda, MD.

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For further information regarding guarantees or other considerations contact

Sharon R. Heinlen, Administrator, Callaway Community Hospital, Hospital Drive, Fulton, MO 65251, 314-642-3376.

# NEWS NOTES

# **New ISMA Members**

The following physicians were welcomed in May as new members of the Indiana State Medical Association:

Brian L. Arnold, M.D., Indianapolis, anesthesiology

Dan J. Bedecki, M.D., Loogootee, family practice

Michelle M. Blake, M.D., Indianapolis, obstetrics and gynecology

Randall C. Blake, M.D., Indianapolis, urological surgery

Michael L. Boothe, M.D., Indianapolis, obstetrics and gynecology

Michael J. Chadwick, M.D., Columbus, family practice

Diana L. Clark, M.D., Indianapolis, family practice

Alex Colalillo, M.D., Logansport, urological surgery

Joseph W. Conner, M.D., Indianapolis, ophthalmology

Sylvia J. Dennison, M.D., Indianapolis, family practice

Peter G. Garrett, M.D., Indianapolis, unspecified

Nabil A. Gayed, M.D., Huntington, general surgery

David L. Gregory, M.D., Columbus, family practice

Eric A. Henricks, M.D., Indianapolis, anesthesiology



Cheryl C. Kinney, M.D., Indianapolis, obstetrics and gynecology

John B. Lange, M.D., East Chicago, occupational medicine

Frank E. Mercho, M.D., Noblesville, radiology

Gary R. Moore, M.D., Indianapolis, orthopedic surgery

Philip Nowzaradan, M.D., Valparaiso, general practice

Chung T. Nuygen, M.D., Indianapolis, internal medicine

James S. Reiff, D.O., Elkhart, unspecified

Nestor C. Reyes, M.D., Indianapolis, family practice

Fernando H. Rivera, M.D., Lake Station, family practice

Mary S. Robertson, M.D., Indianapolis, internal medicine

Kurella T. Sarma, M.D., Beech Grove, general surgery

Larry G. Schachter, M.D., Frankfort, general surgery

Keeter D. Sechrist, M.D., Indianapolis, dermatology

Surendra J. Shah, M.D., Gary, internal medicine

Shannon L. Simpson, M.D., East Chicago, pathology

Lynda R. Smirz, M.D., Indianapolis, obstetrics and gynecology

Randall J. Suttor, M.D., South Bend, family practice

James V. Thomalla, M.D., Indianapolis, urological surgery

Donald T. Tucker, M.D., Gary, family practice

Andrew S. Wachtel, M.D., Michigan City, psychiatry

# Dr. Ruschli Celebrates 100th Birthday

Dr. Edward B. Ruschli of Lafayette, who turned 100 May 15, is now the youngest of Indiana's physician centenarians. (The others are Dr. Herschel Marcus of Indianapolis, who turned 104 on Aug. 1; Dr. Vernon A. Shanklin of Vincennes, who will be 103 on Aug. 31; and Dr. Jesse W. Bowers of Fort Wayne, who will be 102 on Oct. 15.)

Dr. Ruschli, a 1906 graduate of the New York University School of Medicine, was honored at a birthday party held at St. Elizabeth Hospital, where he now lives as a special patient. He was chief of the surgical staff there for many years. Before locating in Lafayette, he completed both an internship and residency at Bellvue Hospital in New York.

Although Dr. Ruschli retired from general practice about 20 years ago, he continued to make house calls and had a limited practice into his 90s.

Among the nearly 300 people attending Dr. Ruschli's birthday reception was one



of his four daughters, Mrs. Barbara Mickelberry of Vero Beach, Fla.

Mrs. Mickelberry said that her father remains, in his mind, what he always was. "He's in his normal atmosphere, and he thinks he's practicing medicine. He told my sisters while we were visiting in January, 'I don't want to be rude but I'll have to excuse myself because I have other patients waiting.' We all get a kick out of that. He is a great guy."

In an interview a few years ago, Dr. Ruschli, an early member of the American College of Surgeons, said, "Medicine is my life. I will do it as long as I breathe.

My key to life is to keep the mind occupied. Life is prolonged on a basis of educating your mind to your profession."

Dr. Ruschli at one time estimated that he delivered about 100 babies a year—in fact, he delivered the first baby ever born at St. Elizabeth Hospital, when it was a 30-bed clinic. One of those he delivered was James Riehle, mayor of Lafayette; the mayor presented Dr. Ruschli with a Distinguished Lafayette Citizen Award during the reception. Congratulatory messages were sent by President Reagan, Governor Orr and the president of New York University.

Dr. Ruschli enjoyed the party. At the end of the celebration, he had a glass of beer, which he maintains has a therapeutic value if used in moderation. Today he's back to his normal routine—frequently advising nurses and doctors how they should handle various situations. They listen. After all, he's been called "Doctor" for 78 years. . . .

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References: 1. Kales J et al: Clin Pharmacol Ther 12:691-697, Jul-Aug 1971. 2. Kales A et al: Clin Pharmacol Ther 18:356-363, Sep 1975. 3. Kales A et al: Clin Pharmacol Ther 19:576-583, May 1976. 4. Kales A et al: Clin Pharmacol Ther 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: J AM Geriatr Soc 27:541-546, Dec 1979. 6. Kales A, Kales JD: J Clin Pharmacol 31:40-150, Apr 1983. 7. Greenblatt DJ, Allen MD, Shader RI: Clin Pharmacol Ther 21:355-361, Mar 1977. 8. Zimmerman AM: Curr Ther Res 13:18-22, Jan 1971. 9. Armein R et al: Drugs Exp Clin Res 9(1):85-99, 1983. 10. Mont) JM: Methods Find Exp Clin Pharmacol 3:303-326, May 1981. 11. Greenblatt DJ et al: Sleep 5(Suppl 1):518-S27, 1982. 12. Kales A et al: Pharmacology 26:121-137, 1983.

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SEPTEMBER 1984

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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

THE FRANCIS A. COUNTWAY
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# ABOUT THE COVER



Among the numerous activities planned for this year's ISMA convention is the General Meeting, during which Indiana physicians will examine the ethical implications of clinical judgment, in keeping with the convention theme, "The Revolution in Patient Care." The pre-convention section begins on page 713. (This year's resolutions will be published next month.)

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# Beware of 'Hold Harmless' Agreements

# A Message from the Executive Director

DONALD F FOY
Executive Director
Indiana State Medical Association

"Hold Harmless" Agreements are increasingly being used as a method to either "transfer" risk or clarify it. There is a growing trend for hospitals, PPOs, HMOs and corporations to request or require "Hold Harmless" Agreements from physicians. This is more evident with respect to certain specialties although it appears to progressively involve more physicians.

In signing such an agreement you may be self-assuming considerable liability exposure since this additional contractual obligation is usually uninsured. Essentially, medical liability insurance policies exclude any liability resulting from a contractual agreement without written approval by the insurance company.

A "Hold Harmless" Agreement is a contractual obligation between the physician and the other party. Many of the agreements state that the physician agrees to hold the hospital, PPO, and so forth harmless in the event that an act or omission of the physician should lead to a liability claim. Consequently, if the physician agrees to a "Hold Harmless" provision, and incurs a liability claim, he would be held personally responsible for all costs pertaining to it including indemnity and legal expense.

We strongly recommend that any agreement containing a contractual indemnification duty be submitted to your insurance carrier before you sign it. Most insurance companies will not accept a unilateral "Hold Harmless" Agreement. Your insurance carrier must review and approve in writing each "Hold Harmless" Agreement to avoid a viola-

tion of the conditions of the insurance policy which could leave the policyholder without insurance for contractual liability.

It should be understood that ISMA is not acting as legal counsel in this regard but strongly urges you to request your personal attorney to review all contracts and agreements before signing them

Although the "Hold Harmless" clauses contained in PPO contracts pose a potential danger, there are other elements in PPO contracts which the prudent physician will want to investigate. Such items include: (1) termination of the agreement and the professional liability that may be incurred; (2) turnaround times on the payment of claims; (3) restrictions on referrals; (4) who is to perform the utilization review function; (5) specified limits of malpractice insurance coverage; (6) method of settling disputes between the PPO and the physician; and (7) the financial stability of the PPO.

# MEDICAL MUSEUM NOTES

CHARLES A. BONSETT, M.D., Indianapolis



LLUSTRATED ON THIS PAGE is a recent monograph by Dr. Leslie A. Geddes, Showalter Distinguished Professor and director of Purdue University's Biomedical Engineering Center. It is entitled "A Short History of the Electrical Stimulation of Excitable Tissue, Including Electrotherapeutic Applications;" it was published earlier this year as a supplement to *The Physiologist* (Vol. 27, No. 1, Feb. 1984).

For the physician who wants to know the electrophysiological background about subjects such as cardiorespiratory resusitation, cardiac pacing, diathermy, electrosurgery, and other such topics, the essentials have been gathered together in this small volume and presented in an interesting and succinct fashion by Dr. Geddes.

Earlier in the year 1 heard Dr. Geddes give a slide presentation on this unique research. The occasion was the 100th anniversary of the organization now known as the Institute of Electrical and Electronic Engineers (IEEE); he was the principal speaker for this central Indiana centennial event.

The history of IEEE's organization is just as interesting for the physician as it is for the engineer. IEEE was co-founded by a Hoosier-born physician, Dr. Norvin Green.

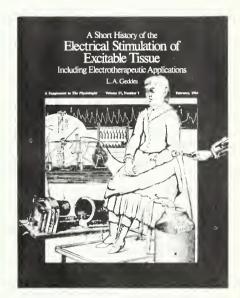
Dr. Green was born at New Albany, Ind. on April 17, 1818, and was an innovative and enterprising individual even from his early youth. At 16, he outfitted a flat boat as a floating general store, making his way down the Ohio and Mississippi Rivers, making a profit all the way.

He received his M.D. degree from the Medical College of Louisville at the age of 22 (1840), and practiced in Kentucky until 1853, at which time he became involved in other endeavors.

Dr. Green's interest in politics put him into the Kentucky House of Representatives from 1851 to 1853, and in the latter year he was appointed U.S. Commissioner of the Custom House at Louisville,



Norvin Green, M.D.



a post he held until 1857. During this time he developed an interest in telegraphy, becoming one of the lessees of the United Morse and People's Telegraph lines between Louisville and New Orleans. He reorganized the various interests of this concern under the name of the South Western Telegraph Company, of which he became president.

Next, he conceived the idea of a national consolidation of telegraph companies, an idea he carried to fruition following the Civil War, by combining his South Western Telegraph Company with other independent companies to form the Western Union Telegraph Company.

Dr. Green was vice-president of Western Union from 1866 to 1878, and president from 1878 until he died Feb. 12, 1893. He was president of Western Union when he became co-founder and first president of the American Institute of Electrical Engineers (as the 1EEE was originally known). He was associated with

a number of other innovative men in this endeavor, including Thomas Edison and Alexander Graham Bell.

At the centennial event, the history of the 1EEE was followed by Dr. Geddes' presentation.

Space does not permit covering the numerous topics discussed by Dr. Geddes. One example, however, is that of Benjamin Franklin, who included electrotherapeutics in his realm of research. Using discharges of static electricity from Leyden jars, he noted the effects on paralysis in a number of patients either by drawing sparks from the patient or by discharging the Leyden jar through electrodes placed over specific areas of the patient's body. Franklin reported the method to be without benefit.

Franklin was scientific in his approach. Many of his followers were not. Dr. Geddes reports that sparks have been delivered to virtually every region of the body and for the most amazing reasons (e.g., infertility and impotence).

# MHAT'S MEWS

The Council on Family Health will distribute its Patient Information Form, free of charge, to any doctor requesting it. The form is designed to be filled out by either patient or doctor during the office visit in order to stimulate a dialogue about all aspects of the patient's use of prescription and nonprescription medicines.

W. D. Scott and Associates has a new computer-based medical management system. It is sold as a total unit, fully installed and operational. Includes an IBM Personal Computer XT, graphic printer, record-keeping software, three full days of training and an on-going network of support services. Scott offers the outfit as a reliable antidote to paperwork paranoia.

The DePuy Company of Warsaw, Indiana makes porous coated artificial hips, into which human bone grows, thus eliminating the need for bone cement. Biological fixation improves its strength with time—cement may become brittle and weaken with age.

Ross Laboratories will fortify its entire infant formula line with taurine, a nutrient found in large amounts in human milk. The new additive is recommended as a result of seven years of basic and clinical research. "While milkbased infant formulas have about onetenth the amount of taurine of human milk, extensive experience indicates current formulas are safe and nutritious," Ross says. Taurine is a unique amino acid which exists in tissues as a free amino acid. It is not utilized for protein synthesis nor is it a source of energy. However, it is a nutrient in the sense that it participates in body functions. It is found free in almost every tissue in the body and is present in large amounts in human milk.

BNA Communications has a new employee training program called CHEMSAFE<sup>IM</sup>, which shows employees how to protect against health and physical hazards of a chemical nature. The system is an eight-module sound/slide or video program which explains chemical hazards and motivates employees to take safety precautions to protect themselves.

Kodak announces the availability of a new fractionated bilirubin system which may be used in the Ektachem 400 and 700 analyzers. Two chemistry slides, BuBc and TBIL, when used and read together, give readings on unconjugated and conjugated bilirubin, delta bilirubin, total bilirubin for adults and neonatal bilirubin for neonates and a value comparable to standard direct bilirubin.

Continental Systems announces the Auto-flow faucet. The water is turned on automatically when hands are placed beneath the faucet and turns off automatically when the hands are removed. All this is accomplished by virtue of an infra-red beam. The faucet is recommended for medical offices, hospitals and restaurants where sanitation is important. It is also appropriate for all other installations by reason of economy of water (up to 75%) and convenience.

Brentwood Instruments announces a portable, single channel, automatic ECG. The Cardimax FX 102 ECG is smaller than a textbook and weighs less than four pounds. It automatically switches through a 12 lead examination. It calibrates the system, positions the stylus and adjusts sensitivity. Recording length of each lead is selectable from I to 10 seconds per lead. A large liquid crystal display shows lead sensitivity chart speed, filter on/off, battery condition, and paper supply.

**Beckman Instruments** has introduced a new test assay in the Epsilon<sup>TM</sup> Immunoassay line to measure hCG (human chorionic gonadotropin) in serum or urine. The test is easy to perform, requires less technologist time and is less costly than traditional assays.

News of what is new in the medical supply industry is composed of abstracts from news releases by book publishers and manufacturers of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by INDIANA MEDICINE or by the Indiana State Medical Association.

Haemonetics is introducing a fourth generation Cell Saver Autologous Blood Recovery System programmed to handle rapid blood loss. It offers fully automatic operation. The latest version of the Cell Saver is suitable for even a wider range of surgical procedures than the previous models. Recommended for use in trauma cases, and for operations for aneurysm, ruptured spleen, ruptured liver and liver transplant.

Schering has introduced Lotrisone® Cream, a unique dual-action topical antifungal product available only by prescription. It is formulated with the antifungal agent clotrimazole and the corticosteroid betamethasone dipropionate. Lotrisone demonstrated statistically significant more rapid therapeutic effects than clotrimazole cream or betamethasone dipropionate cream in the treatment of tinea cruris, tinea corporis and/or tinea pedis.

Amko has a new Hofmeister Endometrial Biopsy curette especially designed for endometrial sampling. It features finer and less traumatic teeth than the Novak curette. It is available in 2, 3, or 4mm sizes, in all stainless steel.

Beckman Instruments has introduced a digoxin assay which produces results in 40 minutes with superior accuracy and sensitivity. The Epsilon<sup>TM</sup> Digoxin test uses non-isotopic competitive binding enzyme immunoassay to generate answers comparable to RIA accuracy.

The first video news magazine for physicians will be launched this fall. "Video Medical Journal" will be issued on videocassettes to subscribing physicians in 10 one-hour programs annually. Since the audience is limited to physicians, subjects may be discussed in intimate detail. "Even the most sensitive and controversial subjects related to medical practice can be discussed without concern that lay viewers will also see the reports." VMJ is not intended to substitute for important print journals but will be able to present, on a video screen, medical information that is difficult to depict otherwise. The price of an annual subscription to VMJ is \$380.

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#### FUTURE FILE

#### Florida Symposium

"Ear, Nose and Throat Diseases in Children" will be the subject of a five-day symposium to be presented Dec. 5-9 at The Breakers in Palm Beach by the Depts. of Otolaryngology and Pediatrics of the University of Pittsburgh School of Medicine.

The course offers 17 CME credit hours. Tuition is \$250 for physicians, \$185 for residents.

Contact the Dept. of Otolaryngology, Children's Hospital of Pittsburgh, 125 De Soto St., Pittsburgh, Pa. 15213—(412) 647-5466.

#### Cardiac Auscultation

"Cardiac Auscultation for Nurses, Nurse Practitioners and Physician Assistants—1984" is the subject of a program to be conducted by the American College of Cardiology Oct. 17 to 19 at the College's Learning Center in Bethesda, Md. The fee is \$330.

Write or phone: ACC, Learning Center Program Registrar, 9111 Old Georgetown Road, Bethesda, Md. 20814—(301) 897-5400, ext 241.

#### Six Days in Boston

The annual scientific meetings of the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation will be held Oct. 21-26 at the Boston Sheraton Hotel.

Contact Creston C. Herold, ACRM/AAPM&R, 30 N. Michigan Ave., Suite 922, Chicago 60602—(312) 236-9512.

#### Indiana University CME

For the Primary Care Physician

Sept. 22—Infectious Diseases, Radisson Plaza Hotel, Indianapolis.

Oct. 1—Hepatitis B Update: Medical/ Legal Overviews, 1ndianapolis.

Oct. 11—Thromboembolism, Arterial Occlusions and Aneurysms: Diagnosis and Clinical Decision Making, Reid Memorial Hospital, Richmond.

Oct. 31—Management of Scoliosis, Holiday Inn, Speedway.

Nov. 2—Management of Orthopedic Problems, Vigo County Public Library, Terre Haute. Nov. 7—Clinical Endocrinology, Adam's Mark Hotel, Indianapolis.

Nov. 28—Ob-Gyn Symposium, 1ndianapolis.

"Mini-Fellowship in Rheumatology" —40-hour course, five consecutive days. For details, see the July issue, page 506.

#### For the Specialist

Sept. 29—Pathology of Muscle, Indianapolis.

Oct. 1-3—Advanced Echocardiology, Hyatt Regency, Indianapolis.

Oct. 10,11—Care of the Seriously Ill Child, Radisson Plaza Hotel, Indianapolis.

Nov. 16—Evoked Potentials Seminar, 1.U. Medical Center.

For additional information, contact the CME Division, Indiana University School of Medicine—(317) 264-8353.

#### **Neurology Conference**

"Neurology for the Non-Neurologist" is the subject of a CME conference Dec. 12 to 14 at the Westin Hotel, Chicago. It is sponsored by the Rush-Presbyterian-St. Luke's Medical Center.

For information, contact the medical center at 600 S. Paulina, Chicago 60612—(312) 942-7095.

#### **Primary Care Update**

"Primary Care Update" will be the theme of the 69th Scientific Assembly of the Interstate Postgraduate Medical Association when it meets Oct. 22 to 25 at the MGM Grand Hotel in Las Vegas.

A faculty of 41 medical educators will conduct lectures, panels and informal group discussions. The program is eligible for 24 hours of Category 1 credit and four hours of Category 5 credit.

For a copy of the program and to register, write 1PMANA, P.O. Box 1109, Madison, Wisc. 53701.

The Journal of the American Medical Association publishes a list of CME courses for the United States twice yearly. The January listing features courses offered from March through August; the July listing features courses offered from September through February.

#### **Pediatrics Symposium**

The 12th annual Fall Pediatric Surgery/Pediatrics Symposium concerning "Care of the Seriously III Child" will be held at the Indianapolis Radisson Hotel, Keystone at the Crossing, Oct. 10-11. The symposium will be sponsored by the Indiana University School of Medicine.

Contact Jay Grosfeld, M.D., Riley Hospital, 702 Barnhill Drive, Indianapolis 46223—(317) 264-4681, or Joni Downs—(317) 264-8353.

#### **Pulmonary Medicine**

"Pulmonary Medicine and Office Spirometry for the Primary Care Physician" is the subject of a CME course to be held Nov. 16 to 18 at the Vacation Village Resort in San Diego.

The fee for physicians is \$295; for residents and allied health personnel, \$195. The course offers 19 Category 1 credit hours

Contact the Office of CME, UC San Diego School of Medicine, M-017, La Jolla, Calif. 92093—(619) 452-3940.

#### **Kokomo Conference**

"Practical Management of Psychiatric and Alcoholic Emergencies" will be the subject of a conference Oct. 25 at Howard Community Hospital, Kokomo.

The program, co-sponsored by the hospital and 1.U. School of Medicine, will provide a practical approach to the management of psychiatric and/or alcoholic patients in the office or emergency room.

To register, contact Bev Woodard, Howard Community Hospital, 3500 S. LaFountain St., Kokomo 46902—(317) 453-0702.

#### Care of the Elderly

"Aging and Illness in Primary Care" is the title of the 4th Symposium on Ethical and Clinical Problems in the Care of the Elderly, to be conducted Nov. 8 and 9 at the Westowner Hotel, Madison, Wisc. The course grants 12 hours of CME credit.

Contact Sarah Aslakson, 465-B WARF Bldg., 610 Walnut St., Madison, Wisc. 53705—(608) 263-2856.

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#### T. S. DANIELSON, JR., M.D., M.P.H. Acting State Health Commissioner

New information from Office of the Commissioner Indiana State Board of Health 1330 W. Michigan St. Indianapolis, Ind. 46206 317-633-8400

#### PUBLIC HEALTH MOTES

The problem of ensuring the proper management of hazardous wastes generated by Indiana industries is an important public health and environmental concern.

In Indiana, the Environmental Management Act (IC 13-7) defines hazardous waste as a solid waste, or combination of solid wastes, which because of its quantity, concentration, or physical, chemical, or infectious characteristics may:

- Cause or significantly contribute to an increase in mortality or increase in serious, irreversible, or incapacitating reversible illness; or
- Pose a substantial present or potential hazard to human health or the environment when improperly treated, stored, transported, or disposed of, or otherwise managed.

These broad definitions are further refined in the state's hazardous waste management rules (320 IAC 4).

The complexity of the existing hazardous waste rules cannot be understated. They are frequently misunderstood and certainly controversial. Not all industrial wastes are hazardous wastes and certain hazardous wastes produced at levels lower than 1,000 kilograms per month have been excluded from the regulatory program, making them "nonhazardous" from a regulatory standpoint.

More recently, the Indiana Environmental Management Board preliminarily adopted a revised hazardous waste management rule that adopts additional federal requirements and establishes stricter procedures in certain areas.

While the generation of hazardous waste is not regulated per se, the generator of hazardous waste has very strict requirements concerning handling and disposal of such wastes once they are generated.

Although hazardous waste generators are generally located near centers of population, nearly all counties of the state have hazardous waste facilities.

The role of the ISBH Division of Land Pollution Control in the hazardous waste management scheme is that of a regulator and enforcement arm of the Indiana Environmental Management Board. Periodic inspections of all hazardous waste facilities (generators and treatment, storage, disposal sites) are conducted to ensure compliance with regulations. Facilities found not in compliance are issued Notices of Violation or Compliance Orders (many with penalties assessed).

Permitting activities of the Division include not only the traditional technical reviews for compliance with engineering and groundwater monitoring requirements but also the review of financial assurance mechanisms that are a part of the overall hazardous waste management program.

New treatment, storage, and disposal facilities are subject to rigorous technical requirements. Some of these include: synthetic liners, leachate collection systems, groundwater monitoring, detailed recordkeeping on the location of wastes, personnel training, contingency plans for emergency situations, closure and postclosure monitoring and maintenance plans which extend care for 30 years after a disposal facility closes, and trial burns for incinerators which must prove 99.99 percent removal efficiency; also among the technical requirements are waste analysis plans that outline testing methods for waste materials and financial requirements that provide mechanisms to assure that the financial resources will be available to properly close and monitor hazardous waste facilities.

In addition to the technical requirements, the Environmental Management Board has stressed the need for adequate public participation in the review process. With this in mind, for any new facility, there are public notice requirements of an "intent to issue" a permit and hearings are held generally in the affected local community.

In an effort to address concerns expressed by the regulated community regarding the lack of adequate disposal facilities, the I980 Indiana General Assembly created the Solid Waste Facility Site Approval Authority. The name is a

misnomer, as the authority has nothing to do with solid waste but everything to do with hazardous waste.

The membership of the authority is established by statute and consists of five statewide members and four local members. Upon issuance of a construction permit by the Environmental Management Board, the Siting Authority is called upon for what is called a "certificate of environmental compatibility." This certificate has the effect of overruling local zoning requirements.

In making its review and evaluation, the Siting Authority must consider the environmental and social impacts of:

- 1. The risk and probable impact of an accident during transportation of hazardous waste.
- 2. The risk and probable impact of contamination of ground and surface water by leaching and runoff from a proposed facility.
- 3. The risk of fire or explosion from improper storage and disposal methods.
- 4. The impact on the county, town, or city in terms of the health, safety, cost, and consistency with local planning and existing development.
- 5. The nature of the probable environmental impact, including the specification of the predictable adverse effects on the following: The natural environment and ecology; Public health, population density, and safety; Scenic, historic, cultural, and recreational value; and Water and air quality and wildlife.
- 6. An evaluation of measures to mitigate adverse effects.
- 7. Concerns and objections raised by the public.

The ability of state and local governments to ensure environmentally sound treatment, storage, and disposal facilities is of paramount importance. Siting of these facilities will continue to be a challenge and confound technical experts, elected officials, and the general public. Indiana has attempted to put in place mechanisms in the public forum that allow for the broad discussion of concerns associated with hazardous waste management facilities.

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Owning an energy efficient house can make you money. Conservation features can more than pay for themselves through reduced energy costs, giving you a handsome rate of return on your initial investment. And the money you save on energy is taxfree. The same holds true when you buy an energy efficient house. The graph (right) illustrates the potential return on investing an additional \$200 down payment in a house with \$1,000 worth of energysaving features.



Tor more details on these and other conservation investment tips, write the Alliance to Save Energy. Return the coupon below and you'll receive Your Home Energy Portfolio, a comprehensive guide to conservation investment opportunities in

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#### WILLIAM M. DUGAN, JR., M.D.

Clinical Oncology Center Methodist Hospital of Indiana, Inc. New information from Indiana Division American Cancer Society, Inc. 4755 Kingsway Dr., Suite 100 Indianapolis 46205

EVERY PHYSICIAN'S OFFICE— A CANCER DETECTION CENTER

#### CANCER CORNER

#### New PE Film

"Proctosigmoidoscopy in the Physician's Office" (Order Code # 3793) is a new professional education film available for distribution through the Division Office Distribution Dept. It is to be used in conjunction with the new colorectal Health Check program.

(An earlier film, "Proctosigmoidoscopy: A Part of the Physical Examination," (Code #3721) has been withdrawn from distribution.)

The new film, intended for primary care physicians, medical and osteopathic students, and allied health professionals, describes the uses of rigid proctosigmoid-oscopes and the new, flexible fiberoptic scopes. The procedure is demonstrated on patients with both types of instruments, and the maneuvers to negotiate turns, folds and valves in the colon are explained.

The importance of this cancer detection procedure in conjunction with digital examination and stool blood testing is emphasized for all asymtomatic adults over age 50. ACS guidelines for frequency are summarized, and the need for proper training and observance of precautions are stated. Criteria for further examination with barium enema or colonoscopy are explained.

Suggested accompanying publications include "Early Diagnosis of Colorectal Cancer" (Code 3311), "The Evolving Surgical Treatment of Rectum and Colon Cancer" (Code 3302), "Colonoscopy and Colon Cancer: Current Clinical Practices" (Code 3356), "Current Status of Fecal Occult Blood Testing and Screening" (Code 3426), and "Early Detection of Colorectal Cancer" (Code 3084).

#### **Unproven Methods of Cancer Management**

A statement on the Immuno-Augmentative Therapy proposed by Lawrence Burton, Ph.D., is available for ordering in limited numbers through the Division Office, Medical Affairs.

This statement can be distributed to medical and lay volunteers, hospitals, medical societies, pharmacies, and your representatives in government.

#### Consensus Program at NIH

The NIH Consensus Development Program brings together biomedical investigators, practitioners, consumers, and representatives of public interest groups to provide scientific assessments of information, drugs, devices and procedures

and to evaluate their safety and effectiveness.

The following are consensus statements developed at recent conferences:

- The Treatment of Primary Breast Cancer
- Adjuvant Chemotherapy of Breast Cancer
- Diagnosis and Treatment of Reye's Syndrome
- Computed Tomographic Scanning of the Brain
  - · Defined Diets and Childhood
  - Hyperactivity
  - Total Hip Joint Replacement
  - Clinical Applications of Biomaterials
  - Critical Care Medicine

Free, single copies of any of the above consensus statements may be requested by writing NIH Consensus Development Program, Division of Resources, Centers, and Community Activities, National Cancer Institute, National Institutes of Health, Blair Building, Room 729, Silver Spring, Maryland 20205.

#### Be Immortal.

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AMERICAN CANCER SOCIETY

For more information call your local ACS unit or write to the American Cancer Society, 4 West 35th St., New York, NY 10001.

#### Breast Videotape

A new Professional Education videotape, "The Breast Evaluation" is now available in ¾" format, Code #3743.04. A systematic breast examination, mammography, and biopsy is demonstrated following discovery of a breast lump. The tape is intended for physicians and medical students.

#### Prostate Examination

The importance of prostate examination when the digital rectal is performed will be emphasized and the use of digital rectal examination for the detection of prostate cancer will be included later in the national colorectal cancer initiative.

The Professional Education Publication, Code #3303, "What Is the Best Test to Detect Prostate Cancer?" provides discussion of the digital rectal examination in prostate cancer detection and can serve as a background document on this subject.



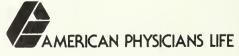
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As an organization accredited for continuing medical education, the Indiana University School of Medicine certifies that this CME activity meets the criteria for one credit hour in Category 1 for the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designated.

To obtain Category 1 credit for this month's article, complete the quiz on page 749.



## Diagnosis, Evaluation and Treatment of the Child with a Simple Febrile Seizure

PHILIP F. MERK, M.D. JOHN E. HEUBI, M.D. Indianapolis

SEIZURE IN A CHILD with fever is a most frightening experience for parents and one of the most perplexing and at times difficult situations for physicians.

In the past there have been many diverse approaches to the diagnosis, evaluation and treatment of the infant who has had a febrile seizure. In 1980, however, the National Institutes of Health held a consensus development conference on Febrile Seizures and issued its report in the *British Medical Journal*, July 26, 1980. Since this report, the definition, diagnostic approach, and the

treatment of these seizures is much more consistent across the United States.

Using the NIH report as a base, we will present one approach to the diagnosis, evaluation and treatment of children with simple febrile seizures. As in all of medicine, there are circumstances which call for exception to any rule and our suggestions should be used only as guidelines.

#### Definition

Approximately 2-4% of otherwise healthy, normal children will have seizures only with fever and only during the pre-school years. These are simple febrile seizures. Their exact pathophysiology is unknown, but many have attributed them to cerebral immaturity.

#### Description

The simple febrile seizure is best described by discussing the characteristics of the child, the fever and the seizure.

Although there is no known mendelian mode of transmission, there does appear to be a strong familial tendency for simple febrile seizures. They occur much more frequently in males than females, although the reason is unknown.

The child with simple febrile seizures must be otherwise normal, have no previous neurologic damage or deficit, and must not have had any non-febrile seizures. The age range for simple febrile seizures is 6 months to 6 years. However, it is unusual for the first such seizure to occur prior to 12 months of age or after 3 years of age.

The exact critical temperature required to induce a febrile seizure is unknown, but some authorities feel that a temperature of 101°F (38°C) is necessary. In the past there has also been some controversy over whether the rapidity in rise in temperature is contributory. It is important to remember that simple febrile seizures occur early in the febrile course.

The source of the fever is of primary importance. To fit the definition of a simple febrile seizure, the source must be outside of the central nervous system. The source is usually a viral infection (such

From the Dept. of Pediatrics, Wishard Memorial Hospital, 1001 W. 10th St., Indianapolis, Ind. 46202.

as respiratory tract infection, gastroenteritis or roseola infantum) although bacterial infections such as otitis media, pneumococcal disease or gastroenteritis obviously may be the etiology of the fever.

The seizure characteristically occurs early in the febrile period, usually within the first six hours. Often it is the first indication of illness in the child. Eighty-five percent of simple febrile seizures are generalized in nature with the remaining 15% being focal. These seizures are typically short in duration, with 50% lasting less than five minutes and 75% lasting less than 20 minutes.

Recurrence of febrile seizures within a 24-hour period is rare, with 2-3% having more than one febrile seizure during a single febrile illness. However, approximately one-third of all children with simple febrile seizures will have more than one febrile seizure during the pre-school period. The likelihood of recurrence of a simple febrile seizure is greater the earlier the age of occurrence of the first seizure. It has been noted that 50% of children with recurrence have one within one year of the first seizure. Finally, if an EEG is done one-two weeks after a simple febrile seizure, it should be normal.

The diagnosis, evaluation and treatment of a possible simple febrile seizure are dependent upon the child's history and physical examination and how closely they conform to the strict definition of a simple febrile seizure.

#### Diagnosis

For the diagnosis of a simple febrile seizure to be made, the following criteria must be met. The child must be otherwise normal with no previous CNS damage, neurologic deficit, or non-febrile seizures. He must be less than 6 years of age and if it is the first febrile seizure must be older than 1 year and less than 3 years of age.

The child's temperature must have been at least 101 °F (38 °C) and must have been of extra-CNS origin.

The seizure usually occurs early in the febrile episode (within the first six hours).

The seizure must be generalized and last less than 20 minutes. There should be only one seizure during a given febrile illness.

#### Evaluation

The extent of the work-up for a child with a simple febrile seizure is primarily dependent upon the history and physical examination. In a child whose history and physical closely conform to the definition of a simple febrile seizure, finding the source of the fever is the primary concern.

The history and physical examination may be all the evaluation necessary in a child who meets the criteria for a simple seizure, has an obvious source for the fever, and has no physical findings suggesting a CNS infection or significant neurologic deficit. In patients without an obvious source for the fever, one or more of the following may be indicated: CBC, blood culture, chest x-ray, lumbar puncture, or urinalysis and urine culture.

#### Indications for Further Work-up

A lumbar puncture should be performed on any sick appearing child without an obvious source of fever or in any child showing the signs and symptoms compatible with a CNS infection. It is important to remember that in children less than 2 years of age the classic findings of meningitis may be absent.

A blood glucose is indicated when a child has a history of hypoglycemic seizures or when the history and physical do not conform to the criteria for a simple febrile seizure. Estimation of the blood glucose by color development on a suitable reagent strip is inexpensive, rapidly interpreted, and easy to perform.

Electrolytes should be obtained when clinically indicated, as with a history of vomiting and/or diarrhea, or clinical evidence of dehydration. Calcium and magnesium levels are almost never indicated in a child presenting as a febrile seizure. Seizures secondary to hypocalcemia and hypomagnesemia occur almost exclusively in the neonatal period.

Skull films are indicated only with a history of significant head trauma and a head CAT scan would be indicated only

with a history of significant head trauma and/or progressive neurologic changes.

An EEG is not indicated in children with classic febrile seizures. It is only when the history and physical do not follow the criteria for a simple febrile seizure that an EEG should be considered. The following would be reasons for obtaining an EEG: the first febrile seizure occurring prior to 12 months or after 3 years of age, occurrence of a focal seizure, a seizure lasting more than 20 minutes, multiple seizures within a single febrile illness, or a history that otherwise differs significantly from the definition of a simple febrile seizure. If an EEG is indicated, it should be obtained one-two weeks following the seizure to ensure the child is in an "non-ictal" state.

#### Treatment

Fortunately, because of the short duration, it is rare that a physician will see a simple febrile seizure. Since, in and of itself, a generalized seizure of short duration is not harmful to a child, the initial treatment of a seizure should consist of placing the child on its stomach with the head to the side, the clearing of any secretions, and close observation, especially for respiratory embarrassment. If the child does have respiratory compromise or if the seizure lasts longer than 10 minutes, one should proceed to stop the seizure activity. Any anti-convulsant may be used, e.g., Valium 0.1-0.2mg/kg IV, Phenobarbital 10mg/kg IV, Dilantin 10mg/kg IV. It is imperative to remember that ANY DRUG WHICH CAN STOP SEIZURE ACTIVITY, CAN STOP RESPIRATION.

#### Hospitalization?

The decision upon whether to hospitalize the child with a simple febrile seizure is dependent upon the child and the family. If the child's clinical condition warrants, if there is any question concerning the etiology of the seizure, or if the parents seem unable to cope with the situation, hospitalization may be advisable. However, for the most part, the benign nature of simple febrile seizures should be stressed to the family and hospitalization avoided.

#### **Prophylaxis**

Prophylactic anti-convulsant therapy is not indicated for the vast majority of children who have simple febrile seizures. There are two groups of children, however, where prophylactic anti-convulsants may be indicated: those children at risk for developing non-febrile seizures, and those children with recurrent febrile seizures whose parents seem unable or unwilling to cope with this condition.

Approximately 2-3% of children with febrile seizures will develop non-febrile seizures. There are several risk factors which help delineate these children. Obviously, a child having an EEG showing an epileptogenic focus should be placed on anti-convulsant therapy. Such a child, however, must have deviated in some way from the strict definition of a simple febrile seizure for an EEG to have been indicated in the first place. Presence of two or more of the following risk factors would also place a child at risk for non-febrile seizures: occurrence of the first seizure prior to 1 year or after 3 years of age; occurrence of a focal seizure; occurrence of a seizure lasting longer than 20 minutes; occurrence of more than one seizure within a single febrile illness; presence of a previous neurologic deficit;

and presence of a family history of idiopathic epilepsy.

The first line anti-convulsant in the prophylactic treatment of children at risk of development of non-febrile seizures is phenobarbital. The dosage is 5mg/kg/day by mouth, divided into two doses. The therapeutic range of serum phenobarbital levels is 15-30mg/ml. Treatment is usually for one-two seizure-free years. It is important to remember that this prophylactic anti-convulsant therapy will not prevent the development of epilepsy. It should also be remembered that phenobarbital may induce hyperactivity or behavioral problems in pre-school children.

The second group of children who may require prophylactic anti-convulsant therapy are those children with recurrent simple febrile seizures whose parents seem unable to cope with the situation. These are usually children who have had three or more simple febrile seizures. Phenobarbital is the drug of choice in these children. As in the previous group of children, a dose of 5mg/kg/day given in two divided doses should give therapeutic levels, 15-30mg/ml. Prophylactic phenobarbital should be continued for one-two seizure-free years. Dilantin is not effective in preventing simple febrile seizures

and, therefore, is never indicated. Although valproic acid is effective in preventing simple febrile seizures, its potential side effects outweigh its benefits.

As was stated in the beginning of this article, we have given only guidelines for the diagnosis, evaluation and treatment of simple febrile seizures. Each case must be considered individually.

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#### Percutaneous Transluminal Coronary Angioplasty: Update 1983

CASS A. PINKERTON, M.D.
JOHN D. SLACK, M.D.
JAMES W. VAN TASSEL, M.D.
CHARLES M. ORR, M.D.
MICHAEL L. SMITH, M.D.
DENNIS K. DICKOS, M.D.
WILLIAM K. NASSER, M.D.
Indianapolis

PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA) is a non-operative method of direct myocardial revascularization using a balloon-tipped catheter to expand and thereby enlarge the lumen of a coronary artery at the site of atheromatous narrowing.

In April 1982, we reported the results of our first 66 PTCA procedures in this journal. We achieved primary success (greater than 20% enlargement in luminal diameter and/or a decrease in transstenotic pressure gradient of greater than 50%) in two-thirds of those cases, and

From the Cardiology Section, Dept. of Medicine, St. Vincent and Community Hospitals, Indianapolis, Ind.

Correspondence and reprints: John D. Slack, M.D., 8402 Harcourt Road, Suite 413, Indianapolis, Ind. 46260.

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concluded that PTCA appeared to be a promising technique for "restoring normal or near normal coronary artery flow . . . in patients with proximal, discrete, concentric, non-calcific, segmental high grade single vessel coronary artery stenoses with normal left ventricular function."

In the past 18 months, these expectations have been fully realized. As expected, with improved equipment and operator skill, the rate of successful PTCA has dramatically increased. In addition, it is now possible to dilate arteries which previously would have been considered unacceptable for the procedure, including distal, segmental, eccentric, and calcific lesions. Most significantly, patients with multivessel disease have undergone successful PTCA with dilation of

each stenosis during the same procedure.<sup>3,4</sup> We wish to summarize our total experience with PTCA over the past three and one half years, with emphasis on calendar year 1983.

#### Materials and Methods

Since the first PTCA in Indiana in September 1980, we have performed a total of 630 dilatations. The patients were referred for evaluation and treatment of symptomatic angina pectoris or an abnormal exercise test. The mean age was 55 years, ranging from 32 to 75 years. Each patient undergoing PTCA was found to have a stenosis of 60% or greater reduction of the luminal diameter in one or more coronary vessels. Patients who did not have unstable angina underwent exercise stress testing prior to the procedure.

TABLE 1
PTCA—Annual Update

	•	
<u>Year</u>	Stenoses Dilated	% Primary Success
1980	10	63
1981	60	76
1982	179	85
1983	381	89

#### TABLE 2 PTCA—Total Experience\* (Sept. 5, 1980-Dec. 30, 1983)

Site	Stenoses Dilated	% Primary Success
Anterior Descending Left Circumflex Right Coronary Diagonal Branch Vein By-pass Graft Left Main Coronary Total	317 [175] 111 [80] 183 [108] 12 [12] 5 [4] 2 [2] 630 [381]	90 [93] 89 [96] 77 [78] 75 [75] 100 [100] 100 [100] 86 [89]
	* 1	983 data in brackets [ ]



FIGURE 1-A: Pre-PTCA left coronary artery angiogram showing a bifurcation lesion involving the mid anterior descending coronary artery and its first diagonal branch.

FIGURE 1-B: Simultaneous inflation of two balloon catheters ("kissing balloon" technique).

FIGURE 1-C: Follow-up coronary artery angiogram six months following PTCA showing continued patency of both the anterior descending coronary artery and its diagonal branch.



FIGURE 1-A



FIGURE 1-C

FIGURE 1-B

All but three procedures were performed using a percutaneous transfemoral artery approach (Judkin's technique). Two cases were performed through a brachial arteriotomy (Sones technique). One case was done using the percutaneous left axillary approach. Since January 1983, the vast majority of our cases have been performed using standard introducers, guiding catheters, and "steerable" balloon systems, which are commercially available from USCI, Billerica, Mass.

#### Results

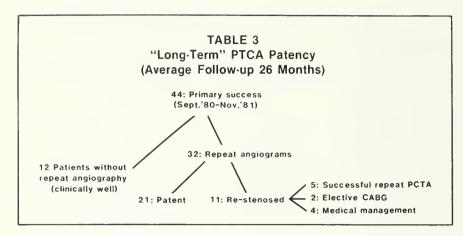
The number of PTCA procedures and our primary success rate is summarized in *Table 1*. The rate of primary success can be seen to increase in parallel with

the number of procedures performed and, indirectly, with increased operator experience. We are extremely encouraged to note a primary success rate of nearly 90% in the cases performed in 1983. Indeed, in the last three months of 1983, our success rate exceeded 93% (103 of 110 successful). These data are particularly encouraging as we are now performing PTCA in more technically difficult situations, including multivessel disease, distal stenoses, branch vessel stenoses, and bifurcation lesions (see Figure 1).

Table 2 more completely defines our PTCA experience, with reference to each vessel dilated. The anterior descending coronary artery continues to be the vessel most frequently dilated and is the vessel with the highest rate of primary success.

The right coronary artery is the second most frequently dilated vessel, but its primary success rate remains significantly less than that of the anterior descending coronary artery. This decreased rate of successful dilatation in the right coronary artery may be explained by its curvilinear configuration and the more perpendicular angulation of its tributaries compared to the anterior descending coronary artery. The ability to successfully approach and dilate circumflex coronary artery stenoses has markedly improved since the introduction of the "Amplatz curve" guiding catheter. Branch vessels, vein bypass grafts, and left main coronary artery lesions have also been successfully dilated (see Figure 2).

Table 2 further separates the data into



pre and post Jan. 1, 1983 periods. The number of procedures performed in calendar year 1983 more than doubled our experience when compared to 1980-82. This is due, in large part, to the extension of indications for the procedure from single, proximal, concentric lesions to other, more complex situations. For example, in 1983, we performed PTCA in 42 patients with multivessel disease, dilating 87 stenoses (five stenoses were dilated successfully in one patient). Our overall rate of success per lesion in these patients with multivessel disease was 95%. We also performed PTCA (in conjunction with streptokinase infusion) in the setting of acute myocardial infarction on six occasions in 1983, with each vessel being successfully reopened acutely.

Finally, and perhaps most importantly, we wish to summarize the "long-term" data available on 32 of the 44 patients previously reported as successfully dilated in our program between September 1980 and November 1981. Angiographic restudy was available in each of these 32 patients (Table 3). Twenty-one patients showed satisfactory patency at the site of prior PTCA. Restenosis was encountered in 11 of 32 patients (33%). Five of the 11 had successful repeat PTCA, two underwent elective myocardial revascularization surgery as they had additional progression of coronary disease at other sites which were not amenable to angioplasty, and four have been maintained on medical management as they continue to be symptomatically and functionally improved despite a degree of restenosis at the site of the previous angioplasty.

Thirty-one of these 32 patients continue to work on a daily basis. Their long-term functional improvement is underscored by the improvement in exercise tolerance on treadmill testing: An average duration of 4.3 minutes prior to PTCA, 9.1 minutes at the most recent evaluation. We continue to be extremely gratified to see that our first patient to undergo successful PTCA in September 1980 has a widely patent vessel at three years (see Figure 3).

#### **Complications**

Serious complications due to PTCA are fortunately uncommon. We have had three deaths during attempted PTCA or during the immediate peri-operative emergency revascularization period. The need for emergency revascularization due to acute closure has decreased, with only 18 patients (5%) requiring such intervention in 1983. Other serious complications we have encountered are stroke (one patient), ventricular fibrillation requiring defibrillation (three patients), and late femoral artery hemorrhage requiring operative repair (one patient).

Minor complications such as vasovagal mediated hypotension/bradycardia, prolonged peri-PTCA chest pain without EKG or enzyme changes, coronary artery dissection without occlusion, groin hematoma, etc. are encountered more frequently, but appear to be of no long-term consequence to the patient. Our success rate and complication rate continue to

parallel that of other experienced operators at major angioplasty centers throughout the country.

#### Discussion

As can be seen, the number of procedures performed on an annual basis has increased exponentially over the past three years. This is probably due to changing referral patterns, with many patients now sent to us directly for PTCA, having undergone cardiac catheterization at other institutions. Additionally, our indications for PTCA have changed so that we no longer limit the procedure to young patients with new onset angina pectoris in the setting of single vessel disease with focal, proximal, concentric, non-calcific lesions. Two factors have enabled us to expand our indications for PTCA to include individuals who previously would have been refused: "steerable" catheter systems and improved operator skill/judgment.

Catheter systems: Since 1980, improved balloon materials and guidewire systems have facilitated a relatively "atraumatic" passage of the catheter through eccentric and/or multiple serial stenoses. The ability to move the balloon catheter "back and forth" across the stenosis along a guidewire enables serial measurements of the transstenotic gradient and serial angiographic evaluation of the success of the procedure. Leaving the guidewire across the stenosis for a period of time following dilatation also permits the operator to deal with late spasm or intimal flap formation by re-entering the distal vessel along the guidewire and molding the area of dilatation with low pressure balloon inflations. Since this technique has been utilized, the incidence of both early and late closure has diminished significantly. The "steerable system" also allows safe threading of the balloon catheter distally in the coronary arterial tree, past many of the side branches which make passage of a nonsteerable balloon catheter virtually impossible. Furthermore, new balloon plastics permit higher pressure inflations of longer duration. These balloon materials, although stronger, also have been made into a lower profile configuration



FIGURE 2-A: Control injection of a saphenous vein bypass graft showing critical stenosis at the distal anastomosis site.

FIGURE 2-B: Balloon inflation.

FIGURE 2-C: Post-PTCA angiogram showing a widely patent distal anastomosis site following angioplasty.

FIGURE 2-A

FIGURE 2-B



FIGURE 2-C

which allows passage through more critically stenosed zones and even totally occluded vessels.

Operator "Learning Curve": Gruentzig, et al. have suggested that a considerable number of cases are required for an operator to become accomplished at PTCA.6 Our results, as summarized in Table 1, reflect the progressive improvement in primary success rate which occurs with accumulated experience. It would appear that approximately 100 cases are necessary to achieve an optimal success rate. Certainly the "degree of difficulty" of each individual stenosis strongly influences an operator's primary success rate, and we have found it prudent for each of us to restrict our PTCA activity to the more straight-forward lesions as outlined in the introduction section above until adequate experience is accumulated. We feel strongly that ongoing review of films and continued consultation between operators before, during and after PTCA procedures contributes to an optimal success rate. (The Indiana Society of Angioplasty was formed in 1982 to enhance such sharing of experience throughout our state.)

#### Conclusion

PTCA is now a proven, viable alternative to direct myocardial revascularization surgery (CABG) for mechanical relief of obstructive coronary artery disease. <sup>7</sup> It can be performed safely and successfully by experienced operators. The indications for the procedure have changed signifi-

cantly in the past year, and now many individuals with multivessel coronary disease have become candidates for the procedure. The primary success rate is acceptably high at 93% and the "longterm" patency rate (81%-26 of 32 patients) at one to two years seen in our patients dilated in 1980-81 compares favorably with the one-year patency rate for coronary bypass grafts.8 Fortunately, PTCA allows easy "re-do" of a restenosis when compared to repeat myocardial revascularization surgery. The 20%-30% restenosis rate seen in our patients as well as those of other experienced operators, is clinically less significant than it may seem, as a second angioplasty can usually be accomplished to give a long-lasting secondary result.9,10



FIGURE 3-A: Pre-PTCA right coronary artery angiogram showing critical coronary artery stenosis.

FIGURE 3-B: Right coronary artery angiogram immediately following angioplasty showing dramatic improvement at the site of previous stenosis.

FIGURE 3-C: Right coronary artery angiogram taken three years following PTCA. Continued patency at the site of PTCA is demonstrated.



FIGURE 3-C

Functionally, patients undergoing PTCA show significant improvement following a successful procedure. It In addition, the ability of the patient to return to gainful employment is enhanced as the in-hospital and convalescence time is a matter of days rather than the weeks and months required for myocardial revascularization surgery. Holmes, *et al.* have shown that significantly more individuals undergoing PTCA returned to gainful employment when compared to coronary artery bypass surgery (85% versus 68%), 12

Nevertheless, we do not feel that angioplasty will replace myocardial revascularization surgery completely. With progression of disease through the years, it is considered inevitable that multivessel, distal disease will develop and direct myocardial revascularization will be required. At present, we view PTCA as a procedure which will delay the need for direct operative intervention until complete, multivessel revascularization is indicated.

PTCA allows selected patients who are functionally impaired due to coronary artery disease to resume a full and active lifestyle and workload for a undefined period of time. These patients require continued medical management and close testing to detect progression of their coronary artery disease. As with myocardial revascularization surgery, the long-term prognosis appears intimately related to the rate of progression of disease at the site of intervention as well as other, previously uninvolved vessels.

Finally, the continuing development of new techniques using catheter-introduced Laser or ultrasound energy sources to "vaporize" atheromata promises even more exciting progress in the field of PTCA in the future. Non-operative myocardial revascularization will likely continue to provide relief of angina pectoris for increasing numbers of patients in a cost-effective, efficient, clinically well tolerated fashion.

#### Addendum

In the first seven months of 1984, we performed PTCA on an additional 344 stenoses. Multivessel angioplasty was performed in 45 patients; the remainder were single-vessel cases. Forty-seven were

undergoing their second or third<sup>2</sup> PTCA. The overall success rate was 92.1%, with 4.7% considered unsuccessful or incompletely revascularized. Emergency myocardial revascularization surgery was required in 3.2%.

We are gratified to report continued high success rates with low mortality/morbidity for PTCA despite ever-expanding indications, as our total experience nears 1,000 cases.

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#### Experimental Medical Devices, Drugs and Techniques

#### Their Future Social, Medical and Political Implications (Part 4)

OTIS R. BOWEN, M.D.\*
Indianapolis

NFORMED CONSENT is discussed in detail in the Nuremberg Code<sup>22</sup> and in The *Declaration of Helsinki* in 1964 at the 18th World Medical Assembly in Helsinki, Finland. The Helsinki Code was revised at the 29th World Medical Assembly in Tokyo in 1975. The Nuremberg Code states only that, "The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent."<sup>23</sup>

The "International Code of Medical Ethics" in the 1949 meeting of the General Assembly of the World Medical Association states: "Under no circumstances is a doctor permitted to do anything that would weaken the physical or mental resistance of a human being except from strictly therapeutic or prophylactic indications imposed in the interest of his patient." However, in 1954, the General Assembly of the World Medical Associa-

tion (in "Principles for Those in Research and Experimentation"), stated: "It should be required that each person who submits to experimentation be informed of the nature, the reason for, and the risk of the proposed experiment. If the patient is irresponsible, consent should be obtained from the individual who is legally responsible for the individual."<sup>23</sup>

The Declaration of Helsinki in 1964 stated: "Clinical research on a human being cannot be undertaken without his free consent, after he has been fully informed; if he is legally incompetent the consent of the legal guardian should be procured." This statement was endorsed by the American Medical Association in its "Principles of Medical Ethics" in 1966. 23

Thomas J. O'Donnel, S.J., separates consent into three types: presumed—in which life-saving measures are done on an unconscious patient; implied—in which tests are done in the process of a general check-up with the consent implied by the fact the person came in for the examination; and vicarious—in which the parent consents for therapy on a child. This classification, however, applies to the ordinary and more routine practice of medicine and does not include the need for informed consent deemed so necessary for experimental use or procedures used for the first time.<sup>23</sup>

The aim of experimentation should be altruistic—to achieve good. One cannot reach this aim without informed consent. Using a person without his consent "is to treat that person as a means to some private or social good. Such acts violate that person's fundamental rights."<sup>24</sup>

It is questionable that the ends always justify the means. The cardinal principle of biomedical ethics is "Do no harm."

There are several principles that will justify first time use of a procedure.<sup>24</sup>

- 1. "A morally important reason."
- 2. "A reasonable prospect that the research will generate the knowledge" or result that is desired.
- 3. The "use should be necessary" and under certain circumstances a "matter of last resort." The use on human subjects should have been preceded by other studies using animals.
- 4. The risks should be outweighed by the potential benefit. The Nuremberg Code says: "The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment."

But, we should remember that definitions of benefits and risks are themselves based on subjective value.

5. "The research must have the subject's voluntary and informed consent."

Informed consent is emphasized over and over and the fact remains that the subject must be informed before being capable of giving consent. Consent must be voluntary and the patient must be competent to understand. Exploitation must be avoided.

"Regarding the sort of information that should be expected, DHEW Guidelines (1978) list the following: (1) A fair explanation of the procedures to be followed, and their purposes, including identification of any procedures which are experimental; (2) A description of any attendant discomforts and risks reason-

Last in a four-part series.

Correspondence: Dept. of Family Medicine, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis, Ind. 46223.

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<sup>\*</sup> Bibler Professor of Family Medicine and Director, Undergraduate Family Practice Education, Indiana University School of Medicine.

ably to be expected; (3) A description of any benefits reasonably to be expected; (4) A disclosure of any appropriate alternative procedures that might be advantageous for the subject; (5) An offer to answer any inquiries concerning the procedures; and (6) An instruction that the person is free to withdraw his consent and discontinue participation in the project or activity at any time without prejudice to the subject.<sup>24</sup>

Alexander M. Capron said: "There are three reasons for informed consent: to promote individual autonomy, to protect the patient's status as a human being, and to avoid fraud and duress."

He said the requirement of informed consent has two parts that must be met before any treatment can really be permissible:

- Sufficient information is given to the patient for intelligent decision making on his part.
- That the patient agrees to the procedure.

These reasons for and requirements of informed consent are expressed in an Illinois Appellate Court decision in Pratt and David:

"The free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person, in other words, his right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent, who has been asked to examine, diagnose, advise and prescribe . . . to violate without permission the bodily integrity of his patient by a major or capital operation, placing him under anesthetics for that purpose, and operating on him without his consent or knowledge.

"By promoting trust and confidence between patient and physician, informed consent requirements may thus advance rational decision making. Furthermore, autonomy is centrally associated with the notion of individual responsibility. The freedom to make decisions for oneself carries with it the obligation to answer for the consequences of those decisions. The requirement of consent for medical interventions thus serves to remind all the participants of their agreement concerning the procedure and their acceptance of those things which arise from its proper execution."<sup>25</sup>

There is another dimension to the ethics of medical experimentation and that is the dilemma caused by randomized selection of those to receive the real thing and those to receive the placebo.

In a sense medical experimentation has been going on forever. Every treatment, every diagnostic procedure, every instrument, every medicine had to be used a first time. Patients with a different or more rare or unusual symptoms or patients who did not respond to the usual or routine methods were understandably subjected to the new. Observation of their reactions to the new made many of the procedures the standard and the acceptable and thus new knowledge originated. The deliberate division of a whole group of people with the same illness into two groups with one group getting the new treatment and the other group purposely getting nothing creates the potential conflict. Does the doctor under these circumstances have his patient's welfare at heart? One can argue that he may have the welfare of thousands of future patients at heart but it is doubtful he has the welfare of those in both divisions of the experimental group at heart. But perhaps that's the difference that must be allowed between the physician with his private patient and the scientist with the future in mind.

Again, the old argument of informed consent creeps in. "Without the patient's consent, such a practice would constitute an unethical violation of the patient's rights and would risk undermining the trust on which the doctor/patient relationship rests."<sup>26</sup>

Informed consent at its best was exhibited at the University of Utah in Salt Lake City in preparation for the implantation of the Jarvik artificial heart. On the other hand, obtaining consent in such a situation might be a little easier than ordinary. The indications for use were that the patient have no chance of survival with death expected momentarily and being the only alternative due to non-

improvable and irreversibly damaged heart muscle. This category includes 10,000 to 15,000 patients a year in the United States.

Richard Saltus, science writer for the San Francisco Chronicle, said: "DeVries the surgeon took one patient down to the cow barn to see for himself.

"The ailing man strolled among the calves tethered in narrow stalls and fingered the plastic tubes sprouting from their chests.

"He listened to the soft, incessant pulse of the air compressor . . . keeping each animal alive. He imagined himself like that.

"Then he went back to the hospital and signed the form.

"I recognize that the ventricles . . . from my own natural heart will be removed and a mechanical heart device will be placed within my chest in the space formerly occupied by my own heart," "read the crucial part.

"'And that this mechanical device will require my body to be attached to an airdriving system by two plastic six-footlong air tubes to pump my blood through my mechanical heart and circulate it through my body."

"In its 11 stark pages the University of Utah's consent form reflects the caution and risks surrounding one of the most dramatic human experiments in medicine. Four patients, including this man, signed the form after Utah last year received the first federal approval to implant an artificial heart.

"If the recipient lived for any length of time with the mechanical heart, he would face an existence so radically different from what anyone has known that its benefits and ordeals can only be guessed at.

"Every heartbeat, night and day, would depend on a fallible machine. The pneumatic heart itself would be on a short leash—six feet of air hose attached to a 375-pound wheeled cart of equipment the patient would have to pull around everywhere and plug into a wall.

"Despite FDA approval there are those who argued that the artificial heart should not be tested in humans because: it could not be completely contained in the body; and even with the best efforts to obtain informed consent, such critically ill patients could not fully understand the nature of their existence after the procedure; there are dangers of machine breakdown or someone inadvertently turning it off with death being sure.

"As a point of interest the University of Utah also has the most sophisticated artificial arm and their bioengineers are working on artificial hearing, sight, blood vessels and a wearable artificial kidney.

"Even though the Jarvik artificial heart held the animal survival record of nine months, the question still arose as to when was it ready for human trial? Had it been adequately perfected? Had it been adequately tested in animals?

"The surgeon who performed the surgery was Dr. DeVries, and as Saltus wrote, is 'A gaunt unassuming man with a down-home manner who heads the university's Department of Cardiovascular Surgery. He has worked on the artificial heart since medical school, and is convinced the heart has a bright future.

"'I know all the physiological reasons why the heart will work,' De Vries said recently. 'But I know very little about the inner self. Will the patient be able to incorporate it into his body image? Will he be afraid to go to sleep?'

"After nearly 25 difficult years of development, the artificial heart has finally reached a stage where such questions are relevant . . . future hearts may be powered by electricity. Nuclear driven hearts have been placed on the back burner because of cost, size and safety questions. The Utah heart poses a huge logistical challenge.

"It means that the patient's house will have to be modified, with all rooms on one level and an air compressor the size of a refrigerator installed in the basement. From the compressor, pipes will carry the air to several rooms equipped with outlets into which the rolling cart will be plugged.

"The cart, roughly the size of an airline flight attendant's beverage wagon, contains two heart drive units from which the air lines, as thick as a little finger, run to the patient's heart.

"The cart also has monitoring equipment and batteries and compressed air tanks to cover power failures.

"The first recipient must live within 45 minutes' drive of Salt Lake City so that doctors can visit him.

"The cart can be carried in an ambulance or van, but until a miniature portable compressor is perfected, the patient won't be able to stroll outdoors.

"Getting an artificial heart is an expensive proposition. The heart itself costs \$10,000—mainly because of the four precision valves it contains—the drive system another \$10,000 and modifications to the house several thousand dollars.

"While many cardiologists and heart surgeons admire Utah for deciding to 'bite the bullet' as one put it, and test the heart in a human, they are hesitant to wish it on their patients—or themselves.

"While agreeing that heart failure patients 'Don't have much of a life' Dr. William Parmley, chief of cardiology at the University of California at San Francisco, said he would not recommend the mechanical implant at this stage.

" 'If it were me, I don't think I'd be too excited about it, if it meant being tethered to an external air source.'

"And, he added, because many patients die suddenly, without pain, 'I'm just not sure if it's a worthwhile thing offering them some kind of false hope."

"... Despite its cost, the device should be cheaper than a heart transplant, said the surgeon, and when mass produced will have the great advantage of being always available. At Stanford, a transplant can cost from \$80,000 for an 'average' case to as much as \$200,000 for a complicated case . . .

"The chance of death within weeks or months is so great, the University's Ethics Committee said, that the potential benefits of the artificial heart outweigh the risks of trying it.

" 'People like this are in effect tethered to a bed,' said DeVries. 'They are in pain if they even get up to brush their teeth.

"They're going to feel a whole lot better with the artificial heart," he said.

"DeVries believes the heart may enable a recipient to walk about the house, work at a desk, perhaps even ride an exercise bicycle. Sex is something 'We're not ruling out,' he said. If such an existence would hold little appeal for someone who is healthy, DeVries emphasizes how one's perspective changes when death is imminent.

"He cited the case of a symphony conductor in his 70's who appealed to him before the experiment was approved. He said he had less than a month to live, DeVries recalled. 'He said if you can put it in me, you can give me life . . . if I can listen to music and write music, that will be enough.' He subsequently died . . .

"Dr. Claudia Berenson, a psychiatrist on the committee, listed some of the qualities the panel will look for.

"The ability to handle anxiety and stress, to live with some hope and some denial (refusal to acknowledge the odds), she said.

"' 'How well have they tolerated being bedridden? And are they people who can be comfortable in a dependent position?"

"Berenson and the others also worry about the effects of the instant fame and prying reporters that are sure to accompany such procedures . . .

"Dr. F. Ross Woolley, chairman of the University's Ethics Panel subcommittee that considered the experimental protocol, said the most difficult ethical issue was determining at what point to consider giving the heart, with its unproven durability, to a failing patient.

"Arguing against intervening too early, he said, is the fact that 'They have a heart that's still working and they're still alive. You're going to remove it and replace it with a device of unknown benefit."

If the surgeons waited until death was imminent, on the other hand, other organs would be damaged and the artificial heart might succeed only in prolonging the end.

"One of our greatest fears is that you set the patient up to fail and put him through anxiety and pain for no benefit," Woolley said.

"The ethics panel resolved the question," he said, "by requiring that a recipient have been at the Class IV stage of illness for eight weeks. This would rule

out any chance of his own heart recovering, but at the same time could leave the patient strong enough to survive the implant operation and give the Utah heart a fair test . . . "27

Dr. Phillip Oyer of Stanford, who favors use of an artificial auxiliary heart, said, "Once you cut the heart out, the guy's pretty well committed."

In the Feb. 21, 1983 issue of *Medical Economics*, well known attorney Melvin Belli throws some cold water even on informed consent when he says it may not always hold up in court. He recounts some of the ways doctors can get into trouble by creating loopholes in informed consent. He said:

"When the patient is rushed, distraught or sedated, a signed consent form may be invalidated. Hurrying a patient into signing a form puts pressure on the patient and does not give him adequate time to weigh the risks. Jurors often identify with patients who've been adversely influenced by the hurrying atmosphere of many medical offices and hospitals. They've been there themselves. Intimidating a patient by frightening him/her into signing a form may also invalidate the form. Patients who are sedated and/or semi-conscious are not themselves and forms they sign may be invalid.

"Use simple English in explaining pro-

cedures, risks and so on. Always ask if the patient understands what you've told him. Record the gist of the discussion.

"If alternative treatment is available, be certain to let the patient know. The operative phrase is 'informed' consent.

"Don't make promises of reward or immunity from risk.

"Oral consent may be as valid as written consent, but make certain you have at least one witness present and document in writing what the patient says."

Texas has tried by law to define informed consent and has established an approved list of potential risks for certain treatments and procedures. The law states that informed consent for these procedures known as "List A" must include specific warning of almost every possible complication and names the complications. The law also names another group of illnesses called "List B" for which no risk disclosure is required. As one might expect, there is great controversy among physicians about which procedures should be on "List A" or "List B" and what potential complications should be described to the patient.

Lawyers also disagree regarding "List B" procedures and many think that every procedure should be on "List A." They also warn that with patients who speak a language other than English, that the doctor will need evidence that he has disclosed the risks in that language either by means of a written translation of the consent form or by way of an oral interpreter.<sup>28</sup>

The conclusion I've reached from reading and preparation of this long paper, is that human experimentation remains absolutely necessary, but that it cannot be done without risk to the experimenter unless he or she obtains full and true informed consent.

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#### Maternal Mortality in Indiana: A Report of Maternal Deaths in 1982

WILLIAM D. RAGAN, M.D. Indianapolis

HE FOLLOWING is the annual report of the Indiana Maternal Mortality Study Committee. A total of five maternal deaths occurred in 1982. In that year Indiana recorded 83,890 live births. This gives the state an official maternal mortality rate of 5.9 deaths per 100,000 births for 1982.

Dr. Ragan is chairman of the Indiana Maternal Mortality Study Committee. An earlier report by the committee, "Maternal Mortality in Indiana: A Report of Maternal Deaths in 1981," appeared on page 579 of the September 1983 issue of the Journal of the Indiana State Medical Association.

Members of the Indiana Maternal Mortality Study Committee are Rick Cross, M.D., Ted Danielson, M.D., Clarence Ehrlich, M.D., Charles Gillespie, M.D., Jesse D. Hubbard, M.D., Charles Kelley, M.D., Elfred Lampe, M.D., Robert H. Oswald, M.D., George Porter, M.D., William D. Ragan, M.D., Sam Ravindran, M.D., Craig Spence, M.D., and Kathy Visovatti Weaver, R.N.

Publication supported in part by a grant from the Indiana State Medical Association. The committee met in open session at Grand Rounds at the Wishard Memorial Hospital June 1, 1983. Several cases were presented and discussed as a teaching experience. Closed session was then held at the Indiana University Medical Center Student Union Building for a review of the remaining cases. Each case was presented for discussion, establishment of final diagnosis, and assignment with regard to preventability and responsibility.

Case #751 was a 31-year-old, G1, PO, at 38 weeks gestation. Cause of death was dissecting aneurysm of the ascending arch of the aorta. This was considered an indirect obstetric death and considered not preventable.

Case #752 was a 28-year-old at term who delivered at home for religious reasons. Cause of death was postpartum infection. The case was considered obstetric and preventable.

Case #753 was a 23-year-old at term who died of postpartum hemorrhage secondary to retained fragments of placenta. She was delivered at home for religious reasons. The case was complicated by the fact that she also had osteogenic sarcoma.

Case #754 was a 29-year-old at term who delivered at home for religious reasons. Cause of death was postpartum hemorrhage secondary to retained products of conception. This was considered an obstetric death that was preventable.

Case #755 was a 32-year-old patient at 10 weeks gestation. Cause of death was herpes simplex encephalitis. This was considered a non-obstetric death.

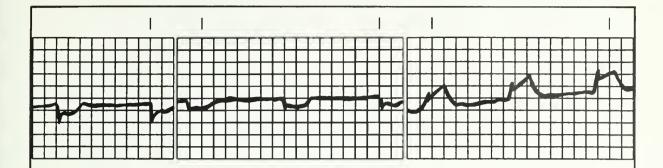
Maternal mortality is still with us. While the numbers are small, the committee feels it is important to investigate and report these deaths for statistical and educational purposes. Undoubtedly, there are many more "near misses." According to our records 50% to 75% of these deaths are preventable or have preventable factors.

In recent years with the liberal use of cesarean section we are seeing an increase in maternal morbidity and on occasion mortality. As reflected in this report and last year's report we are seeing maternal mortality occurring where home births are being carried out without prenatal care or physician involvement. Readers are referred to a recent article on this subject published in Indiana Medicine.<sup>2</sup>

Please report any Indiana cases of maternal mortality to Dr. William D. Ragan, Dept. of Ob-Gyn, Indiana University Medical Center, 926 W. Michigan St., Indianapolis, Ind. 46223.

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#### The Big Brother Act of 1984

#### Commentary

TROJAN HORSE is poised at the gates of Congress. And it looks as though members of Congress are ready to open the gates without taking a good look at the contents of the horse. The unfortunate history of Troy suggests they ought to slow down.

The bill is called the "Civil Rights Act of 1984," but, like the original Trojan Horse, it is not what it appears to be at first glance. Everyone, of course, is for civil rights. This is a lot more.

Hidden behind the rhetoric of civil rights is a radical expansion of federal control over state and local governments and private institutions.

Indeed, those who now refer to the Civil Rights Act of 1984 as the Big Brother Act of 1984 are not engaging in hyperbole. Michael Horowitz of the Office of Management and Budget outlined in a recent memo how the bill "if passed would largely eliminate the remaining distinctions between federal and state, and federal and private, concerns."

The bill would do this by changing the definition of a recipient of "federal aid." Today, if a department of a state government receives federal tax dollars, it falls under certain federal regulations. The same applies for companies that contract work with the federal government. It is understood that there are strings attached to federal dollars. The proposed legislation, however, would expand federal control from the present wording of "any program or activity receiving federal financial assistance" to "any recipient." And such recipients may be covered even if they are "indirect" recipients.

Some examples: If one department or



RICHARD L. LESHER
President
U.S. Chamber of Commerce

agency of a state received federal funds, every agency of the state would fall under federal control, as would every political subdivision of the state, i.e., every city and town. One dollar flowing into one department of a university would bring the entire university under federal control. If this legislation is passed, the concept of federalism—the division of power and authority between the federal, state and local levels of government—would be finished forever.

Not content with bringing your local police station and public school under

Uncle Sam's stern discipline, the legislation also tracks federal dollars from their direct recipients to where they are spent in the private sector.

Does your local grocery store accept food stamps? Does your neighborhood funeral parlor accept veterans who receive military burial benefits? Does your local private hospital accept Medicaid patients? Does your church receive tax-deductible donations?

All these private activities are receiving federal aid "indirectly" and, given the recent record of the courts, would likely fall under federal control as "recipients" of federal aid.

The radical nature of this legislation was largely unnoticed as it garnered 63 cosponsors in the Senate and passed the House of Representatives' Judiciary Committee by voice vote on May 23 after only 10 minutes of discussion. Some members of the Senate, however, have recognized the dangers posed by this bill. Those who take the Constitution seriously can only hope that Sen. Orrin Hatch (R-Utah) holds firm in his commitment to stopping or amending this flawed legislation.

And for anyone who feels my depiction of the wide-ranging nature of the Civil Rights Act of 1984 is alarmist, I would point out that even *The Washington Post* worries that the bill is too farreaching and recommends that Congress "at least understand fully what the consequences of passage may be." And when *The Washington Post* is worried that the federal government is making too large a power grab, it's time for the rest of us to take a hard look at what's going on.



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#### **Economic Development**

#### The Voice of Business

OW THAT A STRATEGIC PLAN for Indiana's economic development has been put in place, it's time for everybody to put up or shut up about job creation and future prosperity, because everybody is needed.

Business people have to become interested and take part. Without them such a plan won't be effective. Labor must be involved; its contribution is vital. University input is a necessity. And government and political leaders have a special obligation: not to let election tactics and personal aspirations undermine this nonpartisan campaign.

The severe recession inspired some extraordinary efforts to remedy our worst problems. The public sector, led by Gov. Orr and Lt. Gov. Mutz, joined with the private sector in acting to retain existing industries and attract new companies. The General Assembly voted massive amounts for programs that promise eventual payoff.

But plans and programs and dollars aren't guarantees. We must make them work to insure future prosperity. Serious concerns need to be addressed.

One concern is what we do compared to what we say. Several recent events are causing the nation's business community to question Indiana's sincerity about creating a top-notch business climate.

Wall Street was astounded last year by the state's intervention in the Marble Hill nuclear project, with its resulting adverse impact on the financial condition of Public Service Indiana. What had been a highly rated utility was placed in jeopardy. Also, changes made in the Public Service Commission have clouded the future stability of utility rates in Indiana.

Election-year rhetoric about which candidate can kick the utilities hardest cerJOHN W. WALLS
President
Indiana State
Chamber of Commerce

tainly doesn't help the state's national image.

Additionally, some of the results of legislative action this year were the worst for business of any session in recent memory.

Local government was given authority to impose large property tax increases on business and industry in the guise of a new local income tax law. Needed reform in banking laws, although supported by Gov. Orr and strongly urged by the Indiana Chamber and other business support groups, was defeated in the House after the speaker personally intervened against the bill.

Equally dismaying, Indiana's reputation as a low-tax, low-spend state is changing.

Nearly all of the additional revenue brought in by the enormous tax increases enacted late in 1982 is being used up in a spending splurge. This change of policy has many business analysts wondering: Will the benefits of the huge expenditures offset the damage done by the higher taxes?

At a time when most state governments are bending over backward to create more favorable business climates, Indiana is sending confusing signals. Some of our actions invite comparison with states that have poor business climates. We can't af-

ford to have business leaders nationwide perceive Indiana as becoming antibusiness.

Organized labor is not visibly trying as hard to help Indiana companies survive and remain competitive as in some other states. Fewer wage reductions and changes in work rules have been negotiated here.

Selling industry on a state that does not have a right-to-work law but does have above-average wage levels and the nation's highest rate of time lost to strikes is very difficult.

Top businessmen nationally see our work force as being unresponsive to employer needs, even when faced with plant closings. While organized labor has done too little to change the negative perception of Indiana's work force, labor leaders in other states have contributed to substantial progress.

Business itself does not escape blame. Business people have not given adequate support to economic development efforts, even though business is a beneficiary. With only a few exceptions, they have abdicated responsibility to state and local governments to make all the effort.

Additionally, they are in part to blame for the poor results of the 1984 legislative session. Many business people neglected to speak directly with their lawmakers when doing so might have affected the outcome of certain critical bill actions.

As our new strategic plan for economic development makes clear, we can't afford to work at cross purposes any longer. Lack of a strong and ongoing commitment to cooperation by every element in the state is a prescription for failure.

If we keep on doing business as usual we will lose industries, jobs and people to the states that do it right.

#### EDITORIALS

#### Turning Back the High Cost of Medical Care

One thing about the high cost of medical care (HCoMC) is that everyone who talks about it blames it on someone else. Someone else or some distant agency.

The HCoMC gets a lot of attention because it is inflating faster than many other essentials. There are a few activities of the federal government which are going up faster than the cost of medical care. However, nobody in government recognizes that fact and the custom is to remain mum about such items as the high cost of mailing letters and to criticize sharply HCoMC.

Many years ago medical care rose in price at about the same rate as other items of the cost of living. What we have now is another animal. The HCoMC is rated by measuring the percentage increase year to year, in addition to calculating the percentage of the gross national product which is spent for medical services. Both measurements increase steadily. It is evident that more and more citizens are receiving more and more care.

Comparing current medical care with that of 50 years ago is similar to comparisons involving a new modern auto and a horse-drawn wagon. We are in the midst of the greatest development of diagnosis and treatment in the history of medicine. Part of the HCoMC is due to

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"The \$75 for repairing it was just a rough estimate. Now that I've smoothed it out, it comes to \$955.25."

this expansion of knowledge and accomplishments.

All the easy diagnoses and economical treatments were discovered a long time ago. When a new diagnostic system is added the total price goes up. When a new treatment system is added, more of the same. Some, but not many, of the new gadgets actually lower the price of treatment and cure. Later on, more and more discoveries will simplify diagnosis and therapy and lower the total cost. In the meantime, the new discoveries will elevate the cost.

If we could eliminate all price inflation, prohibit all medical research, discourage all improvements in therapy and go back to hospital accommodations of 1910, the cost of care would settle down. This method of control, however, will never be popular. When the patient is seriously sick the thought is "Spare no expense," or words to that effect.

Another good plan by then AMA President Dr. Daniel Cloud was outlined several years ago. It doesn't seem to be taking hold very fast. It is not a nickle-and-dime proposition. It will save something like half of the nation's health care bill if it is adopted and followed carefully. Half of the U.S. annual medical care expense is a large fortune—well worth putting on the savings side of the ledger.

The following rule is based on book-keeping statistics from federal government commissions and bureaus—should be reliable. The rule for law and order in the HCoMC is: If nobody used tobacco, if nobody drank alcohol or did so moderately, if everyone ate correctly, maintained normal weight, exercised regularly and drove the auto carefully the medical bill of the United States would be half what it is now.

Big order but very helpful with the finances.

Another part of the HCoMC is called Medicare and Medicaid. Both are varieties of socialized medicine. Accordingly, they obey the universal rule that the cost of socialized medicine is uncontrollable. It goes up each year despite valiant efforts of control.

An analogy will explain the process. If socialists decided to pay everyone's grocery bill, the total food price would increase astronomically. Even with deductions and co-payments the waste and

overuse would bankrupt the country in short order. It's no way to provide food and it's no way to provide medical service.

Attempts to moderate the cost of medical care have consisted of eliminating medical procedures and of lowering the pay scale for what items of medical care are left. Both procedures are likely to lower quality of care, the most important characteristics of modern medicine. We are well on the way to a two-tiered system of medical care.

Labor-management negotiations have a tendency to raise the HCoMC even higher. Fringe benefits have a habit of being insinuated into a labor contract, apparently on the theory that money spent on fringes does not add up as fast as money spent on the hourly wage. First-dollar coverage and other additions are added to ease the method of getting back to work. It all adds up.

It is said that the price of most American-built autos contains a medical care factor as high as several hundred dollars. At one time, not too many years ago, a good American auto could be bought outright for the same number of dollars that are now called the fringe benefit for medical service.

So, if anyone tells you that the HCoMC is due to physician activities and that physicians are responsible for controlling the mess, inform them that the problem is complex, that it might be worse except for the remedial measures taken by the medical profession, and that there is very little for doctors to do except to encourage the public in general and the government agencies to convert the system back to the private practice of medicine as quickly as possible.

#### The Roche CME Network

Hoffmann-LaRoche was a pioneer in the use of television for continuing medical education. In the early 1960s many hospitals did not have television equipment suitable for CME programs for the medical staffs. Roche originally organized a program to aid hospitals in acquiring the equipment. Videotape was found to cost much less than educational films. Roche also formed the Network for Continuing Medical Education (NCME)

and produced or acquired educational programs which could be duplicated and distributed to hospitals for viewing by medical staffs.

Today, the network produces two instructional programs a month, totaling at least 23 hours of programming a year. Program cassettes are distributed in all 50 states and Canada to some 700 hospitals. These range from small community health centers, through teaching hospitals such as those at Johns Hopkins, UCLA and the University of Texas. NCME also reaches research centers such as the Mayo Clinic, Walter Reed Army Hospital and New York's Mt. Sinai Hospital and Medical Center.

The videocassettes, each accompanied with a supply of instructional, bibliographic and self-test literature, may be rented or purchased. Physicians use the cassettes in the hospital or borrow them, like library books, to view at home on their own video equipment.

Roche's continuing sponsorship of NCME means a substantial saving to the subscribing hospitals. Without that support, the subscription cost would triple or quadruple.

#### **Deficit Economics**

#### Guest Editorial

History tells us that from time immemorial many political leaders have tried massive spending of money they did not have: deficit spending. Often this was simply the spending-of-other-people'smoney syndrome on perceived public welfare projects; sometimes it was for the luxurious support of the ruler in the style to which he wished to become accustomed; often it was to engage in warfare for the perceived good of the public or its leaders. Almost invariably it became an addictive habit that led to the downfall and ruin of the rulers and the populace. Our American government is now strongly addicted.

Treating addiction is painful and distressing to the addict; it threatens to be painful and distressing to our national leaders. Few addicts desire to subject themselves to painful withdrawal symptoms; our "Pirates of the Potomac" are likewise lacking in desire to end their addiction because of the perceived result of

their being forced from their well feathered powerful nests if they take the addiction cure.

Let me now point out a few basic economic ideas. First of all, there is no "free lunch" or "free" government dollars; the Pirates do not have a wealthmaking money machine; the dollars squandered have to come from somewhere before they can be squandered. The Pirates use the pretext of borrowing. I call it a pretext. Is anyone so naive as to believe that we, our children, or our grandchildren will ever repay the national debt? The new generations will have their own problems to pay for in their futures; they can't possibly pay these "borrowed" dollars back. Furthermore, these deficit dollars representing wealth have already been squandered.

Now, in the absence of a wealth-making machine in the Pirates' lair, let us look to the source of the wasted dollars and the wealth they represented. The only money that the Pirates can spend must first be extracted from somewhere. Taxation is the only honest way of extraction. The "deficit" wealth has had to come via the confiscation-by-inflation route. Make no bones about it; it has been taken by inflation in the past; it will be taken by inflation in the future—for as long as the voters permit the present crop of irresponsible Pirates to continue their horrendous waste of our national wealth.

Where, on the national horizon, is there any hope for fiscal sanity? I see so little of it. Until the American voters can elect some genuine Statesmen to the Congress, I see no hope. The present crop of Pirates, as well as their predecessors of the last 40 years, are mainly weak, petty ward healers who are more concerned with self than they are with national welfare. They have proven themselves too weak to take the actions necessary to cut down the bureaucracy to an affordable size, and to eliminate the many government activities that benefit only small vocal minorities rather than the country as a whole.

So a few billions may be cut from taxpaid medical and health care expenditures, but that is only a cup full from the ocean of government red ink. If the Medicare-Medicaid budgets were cut to zero, the savings would not be enough to reach a balanced budget. The real mega-bucks will have to be cut from the real mega-buck appropriations for the pork barrel expenditures and other governmental programs and boondoggles. Since our present crop of Pirates are and have been unwilling to do what has to be done, let us hope that we can elect some new congressmen who will act more like Statesmen and less like Pirates.—L. A. Arata, M.D., Shelbyville, Ind.

#### Fat Consumption, Cancer

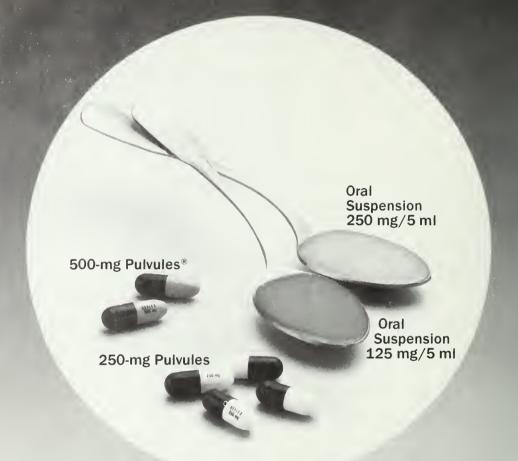
The American Institute for Cancer Research reports there exist increasing research results to indicate that there is a link between fat consumption and cancer. The risk of malignancy and the established fact that high fat intake results in arterial and heart disease emphasizes the recommendations of the National Academy of Sciences Committee on Diet, Nutrition and Cancer:

- Reduce the intake of dietary fat—both saturated and unsaturated—from the current average of approximately 40% to a level of 30% of total calories.
- Increase the consumption of fruits, vegetables and whole grain cereals.
- Consume salt-cured, smoked and charcoal-broiled foods only in moderation.
- Drink alcoholic beverages only in moderation.



"All in all, I had a good day—performed four operations, saw 20 patients and turned down five Financial Planning salesmen."

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#### AUXOLOARY REPORT

Judy Koontz (Mrs. James A.) President, ISMA Auxiliary

We want to show and share with you some of the sights and happenings in Indianapolis during the 1984 ISMA Convention. Dynamic scientific and legislative sessions are being planned plus special joint events for the physician and spouse or guest. The Radisson Hotel is situated in the Keystone-at-the-Crossing complex where shopping and dining establishments are in abundance. In addition, special activities are being planned for spouses of physicians. A Saturday morning bus tour will include visits to the Ronald McDonald House, a favorite project of many auxilians; the Indiana University Track and Field Stadium and Natatorium Building and the newly renovated Circle Theatre, new home for the Indianapolis Symphony Orchestra. The Circle Theatre is a locally designated landmark and is listed on the National Register of Historic Places. The afternoon will be free to attend the IMPAC luncheon or lunch on their own and browse and shop in the area

Sunday morning will be free to attend the church of your choice. A list of all denominations within a short distance of the Radisson will be available at the Registration Desk.

Courtesy transportation will be provided to the Woodstock Country Club for the Auxiliary Day Luncheon. A social hour with cash bar will precede the 1:00 p.m. luncheon. An open board meeting of the ISMA Auxiliary will follow lunch.

At 2:30 p.m. buses will depart for the Indianapolis Museum of Art where there will be a tour of the 11th National Biennial Embroiderer's Guild Needlework Exhibit.

We hope to see many of you in Indianapolis this October. Please show this article to your spouse and encourage attendance at the convention in October. For further information, please contact Rosanna ller at ISMA headquarters. -Jackie Kalsbeck and Barbara Lukemeyer, chairman and co-chairman of Auxiliary Activities.

Friday, October 19, 1984

Auxiliary information/registration

Saturday, October 20, 1984

Auxiliary information/registration

9:00 A.M. Tour buses depart from Hotel for tour of Ronald McDonald

House, Natatorium at IUPUI and Circle Theatre, Downtown

Noon Buses return to Hotel

Noon 1MPAC luncheon or on your own to shop at Keystone at the

Crossing/next to HOTEL

Sunday, October 21, 1984

9:30 A.M.

11:30 A.M. Executive Board Meeting/at HOTEL

Buses leave Hotel for Woodstock Country Club Noon

12:30 P.M. Social Hour/cash bar

1:00 P.M. Luncheon

Open Board meeting to follow

2:30 P.M. Buses depart for Indianapolis Museum of Art Tour of the 11th

Biennial Embroiderer's Guild Needlework Exhibit

4:00 P.M. Buses depart for HOTEL

#### INDIANA STATE MEDICAL ASSOCIATION AUXILIARY

#### **Executive Committee**

PresidentJudy Koontz (Mrs. James A.) Vincennes	Recording SecretaryMartha Stout (Mrs. Francis E.)  Muncie
President-ElectMuriel Osborne (Mrs. John) Muncie	Treasurer
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THE DECISIONS OF CONGRESS AND THE STATE LEGISLATURE REGARDING MEDICAL ISSUES!

THEN... Please complete the form which appears in this publication and return the form promptly. Don't pass up the chance to help determine the direction of medical practice in The United States.

The American Medical Association and The American Medical Association Auxiliary want to ensure that medicine continues to have a positive effect on the political process. They are combining efforts to conduct a national voter registration called PRO-JECT MEDVOTE. This is a bi-partisan effort designed to ascertain what physicians, spouses and voteable age children are registered to vote and to make being registered easier for them. MAKING YOUR VOTE COUNT IS PART OF RESPONSIBLE MEDICAL CITIZENSHIP. You cannot vote however, if you do not have an up to date registration.

In Indiana, we are doing our best to have a deputy registrar representing each of the two major political parties from each county medical society and/or auxiliary, and through them, to help all members of the medical families to be registered to vote.

We are fortunate that in Indiana, we can have deputy registration in the home and at medical functions. WE NEED YOUR HELP IN ORDER TO DETERMINE WHAT MEMBERS OF THE MEDICAL FAMILIES ARE REGISTERED OR NEED

TO BE REGISTERED. REMEMBER: Registration in the home or at a location other than the County Court House can be done until September 27. You can still register after that at your County Court House or designated voters registration location until October 6th. If a child will have become eighteen (18) by Election Day (November 6, 1984) he/she may register to vote and vote. If you will have moved between the last election and November 6, you must transfer your registration. If you have not voted within the last two years, your name has probably been purged from the records and you must reregister.

STAND UP AND BE COUNTED! Please complete the information form appearing in this publication. Indiana is known for interest in politics and good government. With the information which you supply us, we will do our best to get you registered. Remember, however, the final effort is your responsibility. 350,000 A.M.A. members and Auxiliary plus spouses, family and employees = 1,000,000 eligible voters. THAT'S VOTING POWER.

PLEASE COMPLETE THIS FORM AND RETURN PROMPTLY TO: MRS. DWIGHT W. SCHUSTER -6510 N. CHESTER AVE., INDIANAPOLIS, 1N 46220



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SCHOOL ATTENDED/ATTENDING	G	
GRADUATION DATE	DEGREE	
SPECIALTY AREA OF INTEREST		
		IML Q

September 1984

# news notes\_

# Hospital Pharmacy Cost Containment Protocol

A cost containment protocol for hospital pharmacies soon will be available as a result of a symposium held recently in Williamsburg, Va. by a 10-member hospital pharmacy consulting board formed by Abbott Laboratories Hospital Products Division.

The cost containment protocol will be published in two monographs and will provide guidelines for minimizing drug waste and reducing costs related to admixture preparations. The Abbott consulting board is composed of leading experts in hospital pharmacy, including both academicians and practitioners. The first monograph was distributed in late August.

In addition to the cost containment protocol, Abbott's integrated approach to reducing hospital pharmacy costs also includes a newly developed admixture system that will be available in 1985.

On June 14, Abbott announced development of a new wet/dry admixture system called *ADD-Vantage*. The new system is designed for the intermittent intravenous administration of potent drugs that do not have long-term stability in solution.

With the *ADD-Vantage* system, antibiotics and other drugs do not have to be mixed until just before they are administered to a patient. The new system will help reduce pharmacy costs by conserving labor, reducing material cost and minimizing drug waste often caused by changed or cancelled prescriptions.

Abbott also announced that in early 1985 Eli Lilly and Company will begin to supply its line of injectable antibiotics as part of the *ADD-Vantage* system. The company also is negotiating with other pharmaceutical manufacturers to expand the number and types of drugs that will be available in the new system. Abbott expects to conclude a number of additional agreements before the end of the year.

ADD-Vantage consists of two components, a flexible plastic I.V. container partially filled with diluent and a glass vial of powdered or liquid drug. The vial locks into a chamber within the plastic container, and the drug is released by

removing the stopper on the vial, allowing the two components to mix. This simple process is performed by external manipulation of the container, thereby preserving a closed, sterile system.

Abbott will supply the specially designed 1.V. containers containing a diluent. Lilly and other manufacturers that sign agreements to participate in the *ADD-Vantage* program will provide the filled drug vials separately.

#### Five Years of Life Line

The Methodist Hospital in Indianapolis is celebrating the fifth anniversary of its Life Line helicopter service.

Since July 1979 more than 2,700 runs have been completed. Sixty per cent of the patients have been trauma victims with multiple injuries. Others include those with cardiac, acute neurological, pediatric and obstetrical conditions, and patients suffering from exposure or poisoning.

Most of the Life Line runs involve transportation from an emergency department or intensive care unit to an Indianapolis tertiary care facility. However, about 10% of calls received take Life Line to the scene of an accident. Life Line is available 24 hours each day to areas within a 150-mile radius of Indianapolis.

#### Miles' Laser Disc Wins

A laser disc program produced by Miles Pharmaceuticals for the Miles Learning Center has won top award in the Infection Control category of the John Muir Medical Film Festival. The videodisc is one of 10 teaching programs developed for the Miles Learning Center, a unique interactive videodisc system donated by Miles Pharmaceuticals to 255 large teaching hospitals in the U.S.

#### **IMF** Memorial Bequest

The Indiana Medical Foundation has received notice that it is named as a beneficiary in the will of Lester D. Bibler, M.D., in the amount of \$1,000. The bequest, when received, will be added to the investment funds of the Foundation and will be accounted for as a special fund for the benefit of Indiana Medicine.

#### Drug Sales Up in 1983

The U.S. drug industry enjoyed sales increases in 1983, according to information gathered by Pharmaceutical Data Services. The following statistics were reported in a recent issue of "Action in Pharmacy" newletter:

- Retail sales grew by 21%, achieving a new high of \$12.6 billion in this sector of the market.
- The average prescription price rose by 19% in 1983, primarily due to premium-priced new drugs.
- The cardiovascular market registered a gain of 22%, to \$2.2 billion.
- Sales of beta blockers jumped by 27%, to \$687 million. Inderal continued its market dominance in this category, registering sales of \$313 million. Tenormin, another beta blocker, also sold well. Squibb's Corgard increased by 32% to \$86 million in sales.
- As a category, calcium channel blockers turned in the best performance, increasing by 125% over 1982, to nearly \$200 million.
- The anti-ulcer market enhanced its sales figures to \$428 million. Tagamet, the leader, reached \$371 million in sales.
- Sales of analgesics rose by 11% to \$524 million. Eli Lilly and Company has recaptured the lead in this category.

It was reported that although most of the sales increases reflected inflationary price adjustments total unit sales showed an increase of 2% in 1983.

#### Consensus Statements

The National Heart, Lung, and Blood Institute of the National Institutes of Health will conduct a consensus development conference on the subject of Fresh Frozen Plasma Sept. 24 to 26.

The consensus statement of this conference and/or the statement of the conference on hypertriglyceridemia may be obtained on request to Mr. Peter Murphy, Prospect Associates, 2115 E. Jefferson St., Suite 401, Rockville, Md. 20852.

The N1H has also announced it will conduct a consensus development conference on Travelers' Diarrhea Jan. 28-30 at the Masur Auditorium, 9000 Rockville Pike, Bethesda, Md.

#### **New ISMA Members**

The following physicians were welcomed in June as new members of the Indiana State Medical Association.

Ronald M. Ahlbrand, M.D., LaPorte, orthopedic surgery.

Steven K. Ahlfeld, M.D., Indianapolis, orthopedic surgery.

Rex A. Allman, M.D., Winamac, family practice.

Robert J. Alonso, M.D., Indianapolis, neurology.

Thomas R. Anderson, M.D., Muncie, family practice.

Edward Barczak, M.D., Louisville, Ky., diagnostic radiology.

Luis S. Bengero, M.D., Gary, family practice.

William A. Blume, M.D., Evansville, family practice.

Timothy R. Chamberlain, M.D., Columbia City, general surgery.

Larry J. Fineman, M.D., New Albany, internal medicine.

Kathleen A. Galbraith, M.D., Indianapolis, family practice.

David C. Hall, M.D., Indianapolis, neurological surgery.

Katharine L. Krol, M.D., South Bend, diagnostic radiology.

James G. Leatherman, M.D., Indianapolis, family practice.

Gregory B. Millis, M.D., Indianapolis, general surgery.

Michael R. Niemeier, M.D., Indianapolis, pulmonary diseases.

John S. Norlund, M.D., South Bend, therapeutic radiology.



Robert B. Palmer-Ball, M.D., New Albany, internal medicine.

Rhonda M. Pridgeon, M.D., Columbus, neurology.

Frank E. Rabe, M.D., South Bend, radiology.

Zaka-Ur Rahman, M.D., Jeffersonville, cardiovascular diseases. Chang B. Rhee, M.D., Warsaw, diagnostic radiology.

John F. Schaefer, M.D., Indianapolis, internal medicine.

Lance R. Seagren, M.D., Lafayette, emergency medicine.

Kenneth D. Shively, M.D., LaPorte, family practice.

Gregory W. Smith, M.D., Indianapolis, internal medicine.

Bruce K. Sowers, M.D., Fort Wayne, emergency medicine.

Madalyn K. Squires, M.D., Indianapolis, obstetrics and gynecology.

Phillip L. Stiver, M.D., Indianapolis, orthopedic surgery.

Mohammad A. Tabib, M.D., Valparaiso, urological surgery.

James B. Tandy, M.D., Indianapolis, psychiatry.

Samuel E. Toney, M.D., Carmel, obstetrics and gynecology.

Andrew J. Vicar, M.D., Indianapolis, orthopedic surgery.

Josue J. Villalta, M.D., Indianapolis, obstetrics and gynecology.

August M. Watanabe, M.D., Indianapolis, cardiovascular diseases.

Kevin P. Weber, M.D., Santa Claus, general practice.

#### **ASTRA Tech Bulletins**

Beckman Instruments offers a package of technical data bulletins for the ASTRA<sup>TM</sup> Systems' general chemistry tests. Bulletins for 13 tests are included—calcium, direct bilirubin, carbon dioxide, total bilirubin, glucose, sodium/potassium, total protein, chloride, albumin, creatinine, amylase and BUN. The package is free of charge. Write Beckman at 2500 Harbor Blvd., Fullerton, Calif. 92634.

#### Cochlear Implant

The Wright Institute of Otology, Indianapolis, has been chosen by the University of California at San Francisco as one of five investigative organizations to be part of the first U.S. group using a multielectrode cochlear implant.

The cochlear implant is the only U.S. implant known to improve the ability of the deaf to understand speech. Clinical trials will begin this fall.

#### An Ounce of Prevention

Suggestion: Be cognizant of the need to establish a good relationship with your patients, taking time to listen to their complaints and empathizing with them.

Discussion: In a recent malpractice case, the plaintiff's summons named several doctors—except one. When asked why this one particular physician had been excluded from the list of defendants, the plaintiff stated quite simply that Dr. X had been kind to her and seemed to truly care about her condition.

Personal rapport with your patients is not only essential to good care, but it also discourages potential claims against you. It does make a difference.

Defense recommendation prepared by the Medical Liability Mutual Insurance Company, New York, N.Y.

# news notes.

#### Here and There . . .

- ... Dr. Stephen M. Peskoe, director of cardiology at Community Hospital, Indianapolis, received the hospital's Physician of the Year award during the annual George and Margaret Kuhn awards dinner in July; Dr. Kenneth G. Handy, a graduating family practice resident, received the Jane R. Richter award.
- ... Dr. Richard T. Miyamoto and Amy J. McConkey, M.S., Dept. of Otolaryngology-Head & Neck Surgery, I.U. School of Medicine, represented the national clinical trials program on cochlear implants at the FDA Ear, Nose & Throat Devices Panel, which met in Washington in June.
- . . . Dr. Joseph M. Black of Seymour has been re-elected to the Indiana University board of trustees.
- ... **Dr. Mark L. Dyken**, chairman and professor, Dept. of Neurology, I.U. School of Medicine, has been chosen president-elect of the Assn. of University Professors of Neurology.

- the Fort Wayne family practice residency program, has received the A. Alan Fischer Award from the Indiana Academy of Family Physicians for his "outstanding contribution to family practice education."
- ... Dr. David J. Powner is the new medical director of the Dept. of Adult Critical Care, Methodist Hospital, Indianapolis. He is coordinating a series of articles concerning critical care for publication in Indiana Medicine.
- . . . Dr. Patricia A. Keener, an Indianapolis pediatrician, conducted a Safe Sitter training program for youngsters at Lawrence North High School in July.
- ... Dr. Larry D. Lovall of Danville discussed preventive health care at the June meeting in Plainfield of the Alpha Sigma Alpha sorority.
- ... Dr. James P. Stephens, a Crawfordsville family physician, retired from active practice in July.
- ... Dr. Paul F. Muller, retiring medical director of St. Vincent Hospital, Indianapolis, has been named to member-

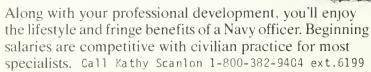
- ship in the American College of Physician Executives.
- ... Dr. George N. Lewis of Bloomington has been named a fellow of the American Occupational Medical Assn.
- ... Dr. Clarence E. Ehrlich of Indianapolis served as a guest professor at a recent seminar in Ireland; it was entitled "Update in Gynecologic Oncology with Emphasis on Cervical Cancer."
- ... Dr. Dean Maglinte of Indianapolis was guest speaker at the Central Florida Radiological Society's June meeting in Orlando; he discussed "Current Perspectives in Small Bowel Radiography."
- ... Dr. Ronald L. Myers, formerly medical director of Lawrenceburg's Community Mental Health Center, has joined the medical staff of St. Alban's Psychiatric Hospital in Radford, Va.
- ... Dr. Jerry E. Neff of Bloomington discussed Alzheimer's Disease at a July meeting sponsored by the South Central Community Mental Health Centers.
- ... **Dr. Terry L. Alley** of South Bend is the new medical director of Renaissance Center, the addictions treatment unit at Elkhart General Hospital.
- ... Dr. Gregory N. Larkin of Greencastle has been re-elected president of the Indiana Affiliate, American Heart Assn.
- ... Dr. Luke B. Mosemann of Paoli is the new chief of the medical staff, Orange County Hospital.
- ... **Dr. Theodore A. Waflart** has been named medical director of the Medco Center, Huntingburg.
- ... **Dr. Bernard E. Edwards** of South Bend has successfully completed the accreditation program of the American Academy of Termology.
- Romberger of the I.U. School of Medicine have been promoted to clinical associate professors of obstetrics and gynecology; Dr. Edwin McClain has been promoted to clinical professor.
- ... Dr. Mason R. Goodman has been appointed the first medical director of Winona Memorial Hospital, Indianapolis; he was formerly director of research at Methodist Hospital of Indiana.
- ... Dr. Glenn J. Bingle of Indianapolis presented an in-service discussion of "Porphyria" for the residents and staff physicians at Memorial Hospital in South Bend in July.

# **Practice Made Perfect**

In Navy Medicine the emphasis is on patients, not paperwork.

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#### Chiropractic Injunction

A rule requiring prior review and approval of all medical services performed by chiropractors was properly enjoined by a trial court, an Indiana appellate court has ruled.

The state department of public welfare proposed rules prohibiting Medicaid reimbursement for diagnostic x-rays performed by chiropractors and limited reimbursement for independent laboratories to services performed by a medical doctor or a doctor of osteopathy only. A trial court issued a temporary injunction barring adoption of the proposed rules and the department of public welfare appealed.

Affirming the decision, the appellate court said that the lower court had jurisdiction to grant the injunction even though the rules had not yet been adopted. The department had no authority to adopt rules requiring prior review and approval of all chiropractic services and not those provided by medical doctors and osteopaths. The court also said that chiropractors were authorized to receive payment for diagnostic x-rays.

—State Board of Public Welfare v. Watkins, 459 N.E.2d 394 (Ind. Ct. of App., Feb. 2, 1984)

#### **Alcohol and ER Patients**

An article in the Annals of Emergency Medicine, published by the American College of Emergency Physicians, reports that 42% of patients in an emergency department in the evening have been drinking and 30% of the patients have consumed a significant amount of alcohol. In a series of patients suffering from concussions, 40% were reported as drunk and 36% had greater than 0.10. The study also showed that there was a high correlation between levels determined by hand-held breath alcohol analyzers and levels determined by chemical measurement of blood samples.

#### Fellowships Announced

Twenty-six medical and osteopathic students have been chosen for Medical Perspectives Fellowships, sponsored by SmithKline Beckman Corp. and administered by the National Fund for Medical Education.

Fellowship projects vary in scope, with some students studying national health care policy and others focusing on the health needs of special populations. Individual fellowships this year range up to \$6,400.

#### **Healthcare Product Catalog**

Medline Industries has published an 812-page catalog of products and services for hospitals and nursing homes. It was produced "post DRG" and is directed at presenting cost-saving products and services.

The Medline catalog is available free to healthcare institutions and can be obtained from local Medline salesmen or by calling 800/323-1368.

#### **AIDS Research**

The Du Pont Company and Biotech Research Laboratories have been granted a license by the Federal Government to produce a virus for an assay system used in the detection of antibodies associated with Acquired Immune Deficiency Syndrome (AIDS).

The assay consists of human T-Cell Leukemia Virus Type III (HTLV-III) which will be used to prepare a diagnostic blood test for AIDS. HTLV-III was isolated at the National Cancer Institute under a research program designed to help detect AIDS, a disorder which impairs the ability of the human body's immune system to fight diseases.

#### Physician Recognition Awards —



The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.



Aeschliman, Dale H., Fort Wayne Andrews, Hugh K., Franklin Ball, George M., Marion Behrend, Frank L., Valparaiso Boen, Bradley N., Indianapolis Boothe, Michael L., Indianapolis Doss, Jerome F., Kokomo Dulay, Dion J., Evansville Estes, Norman C., Indianapolis Feeney, Martin T., Indianapolis Fiacable, Joseph P., Fort Wayne Gillespie, Charles F., Indianapolis Goldschmidt, Max W., Munster

Harris, Garnet R., Danville Jardenil, Romulo S., Lafayette Kennedy, David B., Kokomo Knight, Lewis W., Fort Wayne Kobak, Alfred J., Valparaiso Krueger, Thomas P., Evansville Leman, Eugene, Crown Point Lovall, Larry D., Danville Marshall, Wilbur J., Munster Mason, Earl J., Gary Mendelson, Stanley M., Kokomo Mentzer, William G., Lafayette Minter, Donald L., Goshen

Poracky, Bernard F., Portage Ramker, Daniel T., Hammond Rogers, Robert E., Indianapolis Ryan, C. David, Columbus Saalwaechter, John J., Lebanon Schloss, Robert P., Fort Wayne Snyder, Parker W., Peru Sturdevant, Frank M., Valparaiso Taube, Robert R., Terre Haute Taylor, James A., Anderson Terpstra, William G., Noblesville Villa, Florencio C., Union City Zollman, Charles W., Indianapolis

# NEWS NOTES

#### ACEP Says 'Buckle Up'

The American College of Emergency Physicians has announced it favors the universal use of seat belts in automobiles. Concern was expressed, however, about the government's statement that mandatory passive restraints may not be required if states pass mandatory seat belt

"While we agree with the need for mandatory seat belt laws, we do not see the use of seat belts as an alternative to passive passenger restraints in automobiles," said Dr. Bruce D. Janiak, president-elect of ACEP. "Seat belts should be used in conjunction with passive restraints to help save thousands of lives each year." Airbags and automatic seat belts should be installed in all autos, he said. "The use of active and passive passenger restraints in automobiles could save up to 16,000 lives each vear."

#### **Nutrition Newsletter**

General Mills has implemented a series of "nutrition update" newsletters for health professionals. The newsletter, "Contemporary Nutrition," is distributed monthly, free of charge, to dietitians, dentists, physicians, food technologists, educators, nurses and students.

To receive the newsletter, which features "balanced" literature reviews prepared by national experts, write Editor, "Contemporary Nutrition," General Mills, Inc., P.O. Box 1112, Dept. 65, Minneapolis, Minn. 55440.

#### **Training Grant**

The Pediatric Medical Education program of the Methodist Hospital in Indianapolis has been awarded a Public Health Service training grant of \$476,224 to implement an extensive residency curriculum plan in pediatric education.

#### Midwifery Ruling

A trial court properly enjoined a woman from practicing medicine or midwifery without a license, an Indiana appellate court has ruled.

The Medical Licensing Board of Indiana filed an action against the woman to stop her from practicing medicine and midwifery without the proper licenses. Affirming the trial court's grant of the permanent injunction, the appellate court said that the extensive prenatal care and actual deliveries performed by the woman constituted the practice of medicine.

The court also noted that the practice of midwifery without a license constituted the unauthorized practice of medicine. The court said that the injunction was proper.—Smith v. State of Indiana ex rel. Medical Licensing Board of Indiana, 459 N.E.2d 401 (Ind. Ct. of App., Feb. 7,

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F

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Glucocorticoid Lidex, Syntex Fluocinonide Cream, Ointment DEMULEN

Oral contraceptive Demulen, Searle (combination drug) Tablets

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#### The Convention at a Glance

Indiana physicians will examine the ethical implications of clinical judgment during a Saturday afternoon General Meeting at this year's annual convention, to be held in Indianapolis at the Radisson Plaza Hotel.

In keeping with the convention theme, "The Revolution in Patient Care," two Indiana University professors and two out-of-state guest speakers will address medicine's various ethical issues and dilemmas

The General Meeting speakers will include Dr. J. Lee Dockery, associate dean, University of Florida; Dr. Nancy W. Dickey of Richmond, Tex., vice chairman of the AMA's Judicial Council; Dr. Morris Green, Lesh Professor and chairman of the Dept. of Pediatrics, Indiana University School of Medicine; and David H. Smith, Ph.D., chairman and professor of religious studies, Indiana University.

The convention, which begins on Friday, Oct. 19, will get off to a fast start this year as the first session of the House of Delegates will begin at 1 p.m. rather than in the evening. The first session will be preceded by a half-hour, first-time-

ever new delegates welcome meeting, beginning at 11:15 and hosted by the House speaker and vice-speaker.

(The traditional formal reception and dinner for the Board of Trustees will be held on Thursday evening, Oct. 18.)

On Friday night four reference committees will meet at staggered intervals,

Resolutions to be introduced this year will be published as an insert in the October issue of Indiana Medicine.

beginning at 7 p.m. Two reference committees will meet Saturday morning.

Saturday's schedule also includes the Fifty Year Club luncheon and the annual IMPAC luncheon, which will begin at noon. Mr. Michael Dunn of Michael Dunn and Associates, Washington, D.C., will be the guest speaker.

Relaxation is the order of business for Saturday evening, with the President's Reception at 6:30 and the President's Dinner at 7:30. Tickets will cost \$28.50

per person. The dinner, featuring beef tenderloin with Bernaise sauce and gulf shrimp cocktail, will be highlighted by the Big Band dance music of Bo Thorpe and his Orchestra; the Rocky Mount, N.C. group was a hit at the AMA's annual leadership conference last spring.

Sunday's fare will include a variety of medical section meetings, the past presidents' luncheon, a student/resident reception, the small county delegates' meeting, and a special reception by Dr. Paul Siebenmorgen, chairman of the Board of Trustees.

Cocktails, dinner and entertainment will end the day, beginning at 7 p.m. The evening promises a fine dinner of breast of chicken served with a cream sauce, Morrels mushrooms and white wine. Special entertainment will be provided by "Life," a veteran musical show group that combines choreography and costumes with vocal harmonies and talented brass and rhythm players. Cost is \$22 per person.

The convention will end on Monday, following the second session of the House of Delegates, which will meet at 9 a.m.

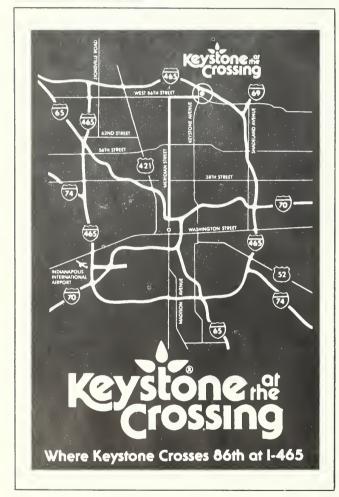
#### Abridged Schedule of Events



GARRY L. BOLINGER, M.D. INDIANAPOLIS

Chairman
Convention Arrangements

135th Annual Convention Radisson Plaza Hotel Indianapolis, Indiana



#### THURSDAY, October 18

#### EST

7 p.m......Board of Trustees Formal Reception/Dinner

#### FRIDAY, October 19

#### **EST**

9 a.m......Board of Trustees Breakfast/Meeting
10 a.m.....Committee on Rules and Order of Business
11:15 a.m....New Delegates Welcome Meeting
11:30 a.m....Board of Trustees Luncheon

1 p.m......First Session, House of Delegates

5 p.m.......House of Delegates Buffet

7 p.m.....Reference Committee Meetings

#### SATURDAY, October 20

#### ES<sub>1</sub>

9 a.m.....Reference Committee Meeting

9:30 a.m....Special Reference Committee (AMA Affairs)

Noon.....IMPAC Luncheon (\$20/person)

Noon.....Fifty Year Club Luncheon

2-5 p.m..... General Meeting

6:30 p.m....President's Reception

7:30 p.m.... President's Dinner (\$28.50/person)

#### SUNDAY, October 21

#### EST

7:30 a.m....Board of Trustees Breakfast/Meeting

9-5 p.m.....Medical Section Meetings Noon......Past Presidents' Luncheon

Noon..... Editorial Board Luncheon/Meeting

2 C. l. (P. 'l. . P. . .'

2 p.m.....Student/Resident Reception

3 p.m.....Small County Delegates Meeting

5-7 p.m.....Dr. Siebenmorgen's Reception

7 p.m......Cocktails/Dinner (General Membership—

\$22/person)

#### MONDAY, October 22

#### **EST**

7:30 a.m....Board of Trustees Breakfast/Meeting

9 a.m.....Final Session, House of Delegates

2 p.m.....Board of Trustees Organizational Meeting and

Executive Committee Meeting



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President
Indiana State Medical Association
1983-1984

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#### Report of Chairman, Board of Trustees

Referred to: Ref. Comm. I ACTION:

The Board of Trustees held its first meeting following the annual convention in Evansville on Nov. 20 at the head-quarters, launching itself into another year of activity concerning the many issues confronting organized medicine.

In my report to you I will cover the actions of the Board which, in my estimation, were somewhat more significant than others. It was an extremely busy year for the Board, and all of the trustees and alternate trustees contributed wisely and conscientiously to the multitude of issues brought before them.

Upon the recommendation of the president, the Board approved the establishment of an ad hoc Peer Review Committee, which was charged with studying and developing recommendations for the Board regarding a PRO proposal and application which would be submitted to the Department of HHS. In a later action the Board authorized a loan of \$59,860 to the Indiana Peer Review Organization for the development of a PRO application for Indiana.

The chairman of the Health Facilities Council was invited to speak to the Board concerning Resolutions 83-31, 35 and 36, all of which related to nursing home issues. Areas of concern included 1) excessive rules, 2) legal penalties, and 3) fiscal impact. All the resolutions were referred to the ad hoc Geriatrics Committee.

Much discussion was held during the year regarding the Medical Licensing Board's system of suspending privileges; as a result, the Board suggested a joint meeting between the MLB and the ISMA leadership to discuss procedures in license suspensions.

Depletion of the Patients' Compensation Fund was monitored by the Board. Such a depletion would result in a substantial increase in the surcharge for the fund. The Board was also informed that in the case of Wamich vs. Cha, et al., the opinion of the Jasper Superior Court held that the Indiana Malpractice Act is unconstitutional, which was indeed a serious development. The Board authorized legal counsel to file an amicus curiae, and/or participate where appro-

priate in an appeal.

In later actions the Board went on record to oppose provisions in any bill that would allow a malpractice claim to be settled outside the parameters of P.L. 146 to support 1) whatever action is necessary to maintain the integrity of the PCF, and 2) a Governor-controlled Medical Malpractice Study Commission. Because of the Board's concern, the ISMA Reports, Siebenmorgen's Notes and Indiana Medicine were used to remind the membership that they have an obligation to serve on medical review panels when requested in order to preserve the integrity of the medical malpractice law (P.L. 146); and to notify the membership of the possibility of an increase in the surcharge for the PCF. At this writing ISMA is in dialogue with the State Insurance Commissioner and the ad hoc Legislative Committee on Malprac-

The Board supported the activities of the Students Against Driving Drunk (SADD) conference, which was jointly sponsored by Eli Lilly and Co., the Governor's Task Force and ISMA.

The Board modified the criteria for membership in the Fifty Year Club.

Recognizing Dr. Peter R. Petrich for his "outstanding leadership" as floor leader of the Indiana delegation to the AMA, the Board presented him with a plaque expressing thanks and gratitude. Dr. Malcom Scamahorn succeeds Dr. Petrich as floor leader.

Senate Bill 430 was strongly opposed by the Board. The bill would have eliminated the requirement that a person with an "unlimited license to practice medicine in Indiana fill the position of secretary of the State Board of Health." The bill, as passed, did retain that wording but made the commissioner of ISBH a direct appointee of the governor as are the members of the board of the ISBH already.

The Board also reviewed and approved the ISMA Group-sponsored Health and Dental Plans as submitted by the Subcommission on Insurance.

The Board also approved as Class A directors of the PICI Board, Doctors O'Neill, Knote, Khalouf, Haley, Siebenmorgen and Mr. Foy; and as Class B directors, Doctors Lukemeyer and Allen.

Concerning convention planning, the

Board recommended that the opening session of the House of Delegates be streamlined, that the ISMA president and president-elect have a place on the agenda before other speakers, and that the House be convened earlier, i.e., noon or 1 p.m.

Frank Holden, president of Holden and Company, presented to the Board a comprehensive one-year communications program, which would emphasize the physician as an advocate for patients' rights. The Board accepted the \$200,000 proposal with fiscal responsibility extended over a two-year period. The basic idea of the PR program originated with the Public Relations Commission's concern about the impact of the federal DRG program on quality and availability of medical care and treatment.

The Board asked the Executive Committee to submit a resolution to the 1984 House of Delegates proposing a dues increase along with specific reasons for the increase. The Executive Committee's recommendation, supported by the Board, is that dues be raised to \$235 annually.

The board recommended that IMPAC contribute funds to Doctors Huber and Knote, who are candidates for seats in the Indiana House of Representatives.

An Executive Committee recommendation to the Board that all Indiana physicians continue to be sensitive to the financial circumstances of each patient and exercise voluntary restraint with respect to increases in fees and services, was adopted by the Board. This came in response to the AMA's request for a voluntary fee freeze for one year.

As usual, the Board heard detailed reports from our AMA delegation as they prepared to attend and participate in the AMA House of Delegates' meetings in Los Angeles and Chicago. Over 200 resolutions and many AMA Board council and committee reports were considered.

The Board reviewed mechanisms of direct and indirect advertising of medical services and endorsed the AMA policy pertaining to such advertising.

The Board was advised that Dr. Lukemeyer, as president of ISMA, had been presented with an award from the International Association of Business Communicators for the ISMA-sponsored television series "Heartbeat," currently

#### Report of Chairman, Board of Trustees

being aired by 27 stations.

Creating a fee review council at the state level to assist constituent county medical societies in effective fee review matters was referred to the Commission on Medical Services.

Making credit card services available to the ISMA membership via the Indiana National Bank VISA card system was approved.

The editor of INDIANA MEDICINE, formerly The Journal, made periodic reports to the Board regarding the editorial and business affairs of the publication.

Reports from both the Physicians Insurance Company of Indiana (PICI) and American Physicians Life Insurance Company (APL) were also reviewed periodically during the year. The growth of both companies is exceeding projected targets; they are deserving of the continued support of ISMA members.

The ISMA officers, trustees and alternates elected by you and the ISMA districts have worked long and hard hours again this year on behalf of our Association. Our loyal, dedicated and effective ISMA staff has done likewise and all have gone the second and third extra mile.

It has been a pleasure to have been associated and worked with these people these past three years as chairman of the Board of Trustees. I trust the Association will join with me in expressing to each of them a hearty, well-deserved "Thank you" for their efforts.

The chairman's report would not be complete without mentioning his personal activities associated with that office. I have not only presided over the Board agenda and meetings for three years, but I have attended the annual AMA Leadership Conferences, all AMA House of Delegates meetings, all but three ISMA district meetings these three years, many

ISMA committee and commission activities, including special workshops and legislative efforts with several trips to Washington, D.C., and participated in multiple negotiating sessions, i.e., third-party payors, and Medical Licensing Board. It was a pleasure to present on your behalf the Charter to the residents for ISMA's first Component Medical Society.

Lastly, I have attempted to keep the ISMA membership informed of the Board of Trustees actions and hope that all have enjoyed the opportunity to "Siebenmorgens Notes" concerning Board decisions these last three years.

I thank you all for the courtesies afforded me during my tenure in this office and I look forward to tackling the challenges before us as we work in other capacities for the benefit of quality medical care for our patients.—Paul Siebenmorgen, M.D., Chairman

#### Report of the Editor, Indiana Medicine

**Referred to:** Ref. Comm. 1 **ACTION:** 

At the end of the third quarter of the fiscal year 1983-84, the actual income was about \$10,000 better than was expected and the expenditures were about \$12,000 below the budget figures. This financial cushion should persist throughout the fourth quarter.

Increases in income were due to substantial hikes in subscriptions for individuals not paying dues, local advertising, classified advertising, sale of reprints, subsidies for articles, CME subsidies, and a large increase in the size of the Physicians' Directory.

We have received an adequate supply of a wide ranging variety of articles on clinical and socio-economic subjects. Specialization in short articles and the subsidies received for articles which were necessarily longer than the customary two-page limit has made it possible to reduce the backlog of articles to less than six months. This, in turn, will allow planning for several new and unusual types of scientific writing in the future.

A readership study was performed on the February issue by David Labson, who is skillful and well respected in the assessment of medical publications.

Questionnaires were mailed to 500 chosen-at-random members of the Association. Those responding numbered 293, a very satisfactory 58.6%.

The responders who read each issue thoroughly added up to 65%. Those who read at least one issue in four were counted at 85%.

On a qualitative vote, 92% of the participants stated they wanted to continue receiving the magazine. On a scale of one to five, quality was rated at 3.5 and the need for publication at 3.3.

Why read INDIANA MEDICINE? For clinical articles said 72%, for news—50%, for CME articles—48%, for editorial and commentary—75%.

"What's New?" was read by 88% and the medical history features received an okay from 80%.

Suggestions for improvement—many sincere and thoughtful suggestions were received. These will be considered by the Editorial Board and the Consulting Editors and will be adopted whenever possible.—Frank B. Ramsey, M.D., Editor

#### Report of Resident Medical Society

Referred to: Ref. Comm. 2 ACTION:

During its first year of existence, the Resident Medical Society has represented the ideals and opinions of Indiana's resident physicians at the local, state and national level. In December, the RMS sent its first delegates to the AMA Resident Physician Section's interim meeting. In Los Angeles the delegation introduced a resolution on behalf of the Indiana RMS which pledged a commitment to reduce deaths and injuries due to drunk driving. This resolution was eventually passed by the AMA House of Delegates, after passage by the Resident Physician Section. Meanwhile, at the state level residents have been given the opportunity to discuss their concerns for the Indiana Peer Review Organization and proposed Indiana legislation in 1985 with speakers at monthly RMS Governing Council meetings. Issues of local concern within a training program or institution have also been addressed by the group.

In June, an experienced delegation attended the AMA-RPS annual meeting and successfully guided a controversial resolution calling for increased taxes on alcohol and tobacco designated for the Medicare fund through the Resident Physicians Section. This resolution was forwarded to the AMA for study. Again, the concerns of Indiana's residents were effectively represented in the national arena.

In addition to increasing the representation of Indiana residents, the Resident Medical Society has embarked on a major recruitment campaign for ISMA and RMS members, and has established communication links for organized medicine at every hospital in Indiana with a residency program. These communication links, known as key contact residents, have helped the RMS stay in close contact with the residents scattered among seven Indiana cities and meet the needs of residents at individual hospitals. In March, the RMS also started publishing a quarterly newsletter entitled *RMS Vital Signs*.

The Resident Medical Society has made an effort to provide educational programs for residents. Recent meetings have included discussion on borrowing money, stress, and organizing and financing the professional practice. These programs gave residents the opportunity to prepare themselves for their future in medicine and discover the action they can take during their residency to ease the transition into private practice.

Since members of the RMS vividly recalled the anxiety they experienced when they left medical school to begin their residency in Indiana, they decided their first large-scale service to residents would be to conduct an educational program and reception to welcome residents to the practice of medicine in Indiana. On June 27 a standing room only crowd demonstrated the need and desire of

residents and their spouses/significant others for more programs of this kind. Resource people and sponsors for the "Welcome" program have also indicated their enthusiasm for making it an annual event. Members of the "Welcome" committee are to be commended for their hard work and dedication which made the evening an overwhelming success.

The highlight of my year as RMS president was during the first interim meeting of the RMS on April 14. At the conclusion of the day's educational program and business sessions, Dr. Paul Siebenmorgen, chairman of the ISMA Board of Trustees, presented the RMS with the first component society charter issued by the Indiana State Medical Association. After striving for months to establish a firm foundation for residents today and in the future, our efforts as initial members of the Resident Medical Society were rewarded. The historic presentation denoted the vital role residents will play in the future of organized medicine and the importance of their involvement in the ISMA.

I believe the Resident Medical Society has made some remarkable accomplishments for an organization in its infancy and I am sure it will continue to make great strides in the future.—F. Steven Land, M.D., President

Trustee reports not received at press time will be published in the December 1984 issue of INDIANA MEDICINE.

All Trustee Reports referred to Reference Committee No. 1

### First District ACTION:

Members of the First District Medical Society spent a considerable amount of time and effort to host the ISMA annual convention in October 1983 in Evansville. Delegates secured passage of two resolutions, but were unsuccessful in campaigning for Dr. Forrest Radcliff, candidate for vice-speaker.

The First District annual meeting was held May 10, 1984, at the Evansville Country Club. Presiding at the meeting was Dr. Kent McKinney, First District president. He welcomed ISMA officials and staff in attendance. Reports were given by Dr. George Lukemeyer, ISMA president; Dr. E. DeVerre Gourieux, First District trustee; and Dr. Gilbert M. Wilhelmus, AMA delegate from Vanderburgh County.

Dr. McKinney thanked Dr. Donald R. Elder, vice-president, and Dr. Jeffrey C. Rendel, secretary-treasurer, for their cooperation during the year. New officers elected at the meeting were Dr. Elder, president, Dr. Rendel, vice-president, and Dr. Gary L. Beck, secretary-treasurer. The minutes and financial statement were approved as mailed.

Dr. McKinney presented an art print to Dr. and Mrs. Bruce Romick for cochairing the committee hosting the state convention and commended them for their excellent organization. Dr. McKinney also announced the winners of the golf tournament, in which 40 members participated.

Following an excellent dinner, the audience enjoyed entertainment provided by the Evansville Musicians' Club Chorus, several of whom are First District members.

A special area of concern for First District members this past year was passage of regulations by the Medical Licensing Board of Indiana. Many of our physicians had input into drafting the regulations, which ensure the protection of Indiana citizens without endangering the practice of medicine.

We would like to thank ISMA staff for their efforts in lobbying on behalf of all members of First District. Many bills were introduced during the short session of the 103rd General Assembly. We anticipate an even greater number next year and will be encouraging members to contact their state legislators on issues affecting the medical community. We also suggest that members support the Indiana Medical Political Action Committee with their financial contributions.

We appreciate the efforts of those physicians who served on ISMA commissions. We would also like to thank Dr. Wallace Adye, Jr., alternate trustee, who is serving on the Indiana Peer Review Organization board.

Membership in First District decreased 4% to a total of 450 members as of Dec. 31, 1983; 54% of First District members belong to the AMA.—E. DeVerre Gourieux, M.D., Trustee

# Second District ACTION:

Another year has passed with the increasing challenge of addressing the massive increase in government "involvement" in medical care. Most of us consider this an erosion and invasion of the doctor-patient relationship we have enjoyed in the past. Physicians have been "mandated" to become involved in government programs, and all the private sectors seem to be holding us responsible for properly initiating these programs. Your ISMA hopes to present the united front needed to "temper" and cope with these programs.

The years' issues confronted by your trustees, ISMA officers, and ISMA staff have always been complex and controversial but this has at least doubled now with the increase in government "involvement." During the year, we have been called a "do-nothing group." I assure you that this is not the case. The decisions are made by a group of physicians representing different geographical areas, different specialties and different personalities. This produces a wide diversity of opinions but hopefully provides a decision around which all alternatives have been intelligently considered.

A few of the year's issues are as follows:

- 1. Obviously, the most significant of these issues was the enacting of the DRG program. Space does not permit commenting adequately on this issue; however, the data, as it is coming in, seems to be showing that DRGs actually increase medical costs. Again, it will be questionable as to whether Congress will listen to the facts.
- 2. Also mandated in this temporal law was the PRO. Your ISMA has decided to shoulder the responsibility as the PRO for Indiana. Again, this was very controversial and some members are opposed to this. With this "given" bitter pill, I ask you to consider the alternative groups that are waiting to acquire this control should it not be assumed by the ISMA.
- 3. Your Board decided against litigation on the VIP program since it was thought to be floundering at this time. Also, our council could only give us a 50-50 chance of successfully opposing this.
- 4. During the year, the legislature saw fit to change the manner of selection of the director of the State Board of Health.
- 5. The Physicians Insurance Company of Indiana has thrived (much to the dismay of some members) and the malpractice crisis is again looming on the horizon. Some constituents have already reported that malpractice insurance is unavailable from some companies in the state, simply because of the risk group to which the physician belongs.
- 6. Paramedical personnel and limited licensed practitioners continue to make legislative inroads into the medical care system. Optometrists, chiropractors, nurse midwives, audiologists, pharmacists, clinical psychologists, physical therapists, nurse practitioners, podiatrists, and others are seeking legislative action to obtain admitting and clinical practice privileges inside the hospitals. Many of us feel this is inappropriate and will actually raise medical costs. Also, it will permit inappropriate hospitalizations by untrained, limited practitioners.

The preceding issues (and others) are still an ongoing controversy among your Board members and the membership itself. These can be best dealt with on a 10

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unified front (i.e., organized medicine). The lower levels of organized medicine are becoming more important and their participation as members of the ISMA must increase in the future. The committees' and commissions' representation also must continue to improve. These efforts must be extended if we are to continue to provide the high standard of medical care that we presently practice and which is only found in the United States.

Last year, the Second Medical District meeting was held on June 29 at the Elks Club in Vincennes. Dr. Frederick Buehl presided, with Dr. Roscoe Vaughn serving as secretary-treasurer. The informative presence of the ISMA officers and ISMA staff was greatly appreciated and enjoyed. A program of "Physician Burnout" was presented to the membership and their spouses. The I984 meeting will be hosted by the Daviess-Martin County Medical Society in Washington, Ind. Dr. James Beck will serve as president and Dr. Robert Heymann as secretary-treasurer.

Dr. Paul Wenzler and I continue to represent your interests at the regular ISMA Board of Trustees meetings as well as at special sessions and the annual ISMA convention. We would like to express our thanks to the membership of the Second Medical District for allowing us to represent them as trustee and alternate trustee. I am looking forward to representing you three more years as trustee, if re-elected this summer. Thanks also go to the excellent ISMA staff for their continuing beneficial assistance throughout the year.—Ralph W. Stewart, M.D., Trustee.

# Third District ACTION:

As your trustee, I have attended all Board meetings and would encourage members with any current concerns to contact me and to keep abreast by reading ISMA Reports, Board reports and INDIANA MEDICINE.

Our district meeting was held April 27-28, I984 in New Albany. A panel discussion of pertinent ISMA issues was moderated by Dr. Everett Bickers, president. The panel consisted of ISMA

district and state officers and ISMA staff. Officers elected for 1984-85 were Dr. Wallace Johnson, president, and Dr. Peter Livingston, vice-president. Lawrence County will host the Spring 1985 meeting.

The Board is constantly reviewing reports and actions taken by the Executive Committee, commissions and committees, AMA delegates, Medical Licensing Board actions, Physicians Insurance Company of Indiana and American Physicians Life, as well as others. Some of the highlights during this past year are listed below.

ISMA Income—54% from membership, 21% from interest, and 25% from ads, airplane usage, annual meeting, etc.

**ISMA Expenses**—43% for salaries and benefits, 12% for travel, 5% for building, 12% for printing and 28% for phones, postage, insurance, etc.

**Dues Increase**—At the annual meeting, a dues increase will be considered for 1985. We must seriously consider a dues increase if we are going to continue the kind of programs we have been providing.

Indiana Physicians Review Organization (IPRO)—Indiana physicians have formed and funded the initiation of IPRO and by the time of our annual meeting, this organization may possibly be existing and functioning.

Mandatory Medicare Assignments— This bill was defeated thanks to physicians throughout Indiana who called their congressmen, and ISMA and AMA lobbying efforts.

**Public Relations**—ISMA funds available from our last two years' special dues will be used for public messages that will emphasize the physician as an advocate of patient rights.

**Medical Liability**—We have learned that claims are increasing. The surcharge has been increased and ISMA will need to continue monitoring the Patient Compensation Fund.

Legislative Issues—ISMA members and staff spent a considerable amount of time on legislative issues this year, which is an important function of our organization. One of the bills that is now affecting us all is the Generic Substitution Bill.

I encourage all counties in our district to make sure that their delegates are ready for our annual meeting in Indianapolis Oct. 19-22. We will no doubt be discussing the dues increase, emergency and/or satellite clinics, plus various other reports and resolutions.

At our I983 meeting, we did have delegates representing Clark, Floyd, Lawrence and Harrison-Crawford counties. There was no representation from Orange, Scott and Washington counties. We look forward to seeing all these counties represented at our fall meeting this year.

I really enjoy the opportunity to serve as your district director and if you should have any concerns at any time, please write or call. I do visit some of the county medical society meetings and will be attempting to do more of this.—R. G. "Dick" Huber, M.D., Trustee

# Fourth District ACTION:

The Fourth District Medical Society held its annual meeting on May 30, 1984 at the Madison Country Club in Madison. I would like to give my sincere appreciation to Dr. Howard Jackson and Dr. George Alcorn, as well as the members of the local medical auxiliary in Madison for providing such a wonderful day of entertainment for the guests. The evening speaker at the dinner was Dr. Walter Daly, dean of the I.U. School of Medicine. Golf awards and tennis awards were given. The meeting next year will be held in Columbus. Newly elected president of the Fourth District will be Dr. William Cooper. Other officers were also elected that day.

The past two years, the Fourth District Medical Society has elected a floor leader to guide the members during the annual meeting in October. Elected again this year as the Fourth District floor leader was Dr. Ed Probst of Columbus.

This past year has been very significant in regard to many issues concerning organized medicine. The ISMA Board of Trustees has taken a very progressive approach in confronting many of the problems facing us at this time. I was quite pleased to participate and vote for the new public relations program which will be carried out in Indiana. I feel that this

is a very wise use of our funds and if the medical profession is to stay in the forefront as a free enterprise organization, this type of public relations is quite necessary.

Another issue confronting us during this next year will be that of a dues increase and consideration of either renovating or obtaining a new building. Although a dues increase is never fun, I think that one will be necessary and the Board of Trustees is recommending this to the House of Delegates during our annual meeting in October.

Finally, I feel that the most important concern facing us this year, as in the past several years, is malpractice. The most progressive step taken by our organization in the last several years has been the formation of the malpractice insurance company. This is a growing company and as we look at the annual increase of members making use of this malpractice insurance, we can see that it is growing quite readily. I would urge everyone every member of the Indiana State Medical Association—to consider purchasing this malpractice insurance in the future. This is the main hope that we have to control malpractice costs in this state, and it is to everyone's advantage both financially and politically to carry their malpractice with this company. Even if you had another carrier in the past, I would urge you to at least obtain quotations on prices from our new company. Their prices are competitive and when you obtain a total bid from any other company, the State Medical Association's will be as low as any fee charged.

I have enjoyed to continue being trustee of the Fourth District and hope that I can continue serving my district well on the Board of Trustees.—Mark M. Bevers, M.D., Trustee

## Fifth District ACTION:

At press time, the Fifth District has scheduled its annual Medical Society meeting for Sept. 5, 1984 at the Windy Hills Country Club in Greencastle, with James Johnson, M.D., president, presiding and Peggy Sankey Swaim, M.D., secretary-treasurer, again handl-

ing the financial affairs. With the incomparable John Talley, M.D., as the scheduled feature speaker, a large turnout is expected once again.

Last fall's Fifth District meeting in Terre Haute was well attended and district members had an excellent opportunity to discuss their medical concerns with a large group of ISMA staff and officers including John Knote, M.D., then president of ISMA.

The report of the activities of the Fifth District trustee can best be reviewed by reading the "Chairman of the Board of Trustees Report," as I have functioned in that capacity for the last three years. I have completed the limit of two consecutive terms and, according to ISMA Bylaws, am not eligible for re-election. Therefore, there will be a new trustee elected at the Fifth District meeting on Sept. 5, 1984.

It has been a pleasure and a distinct honor to have been able to serve as your Fifth District trustee these last six years and I have tried to present your views in all pertinent discussions. I thank you for that opportunity. I must also thank Howard Grindstaff and Sara Klein, ISMA field staff, for their excellent help through the years and must give a special thanks to Benny Ko, M.D., our Fifth District alternate trustee, who has done a yeoman's job on behalf of our district on numerous occasions and particularly when I have been occupied with other ISMA responsibilities.—Paul Siebenmorgen, M.D., Trustee

## Ninth District ACTION:

During the past year, we have again been made keenly aware of attempts by the federal government and third-party insurance carriers to standardize and regulate providers of medical care. As a result of these attempts to invade and control, I am pleased to report that Ninth District physicians are making a positive response. This is evident by an increase in support of IMPAC. I strongly urge those who are not yet members to join and participate by voicing your desires to state and national legislators. This is where we must work for the preservation

of free enterprise and medicine.

We physicians in the Ninth District are fortunate to have many interested and willing to spend time and assist the leadership of ISMA in developing policy and speaking on our behalf. Our commission and committee members have served us well and we are grateful for their efforts. A prime example was the excellent seminar and subsequent development of a program now available to assist impaired physicians in our state. Again, this represents a positive approach taken in response to a problem that is evident.

Our Ninth District meeting was held in Rensselaer on June 12, 1984 and hosted by Dr. Robert Darnaby and other Jasper County physicians. They provided an excellent setting at the Curtis Creek Country Club and those in attendance were treated with an updating and informative discussion led by Dr. Lukemeyer and the ISMA staff. The after-dinner speaker, former governor Otis Bowen, M.D., spoke on "Medicine of the Future." He predicted an increasing rise in medical care costs due to the evident increasing age of our population and demands for top priority care. He also predicted increasing efforts by the government to control costs. In response, he recommended that physicians continue to upgrade their knowledge in medicine with continuing medical education, spend part of their time in community service and actively participate in the political process.

I am grateful for the opportunity to serve as your trustee and continue to welcome your comments as we attempt to represent each of you on the ISMA Board.—Max N. Hoffman, M.D., Trustee

# Tenth District ACTION:

Dr. Mary Carroll completed 1983 as president of the Lake County Medical Society and is followed by Dr. Barron Palmer for 1984. In Porter County, Dr. John Swarner was 1983 president, presently followed by Dr. James Malayta.

The Medical Care Share program implemented by the county society for Residents in Temporary Need of Medical

Services has been highly successful. Some 60 physicians have volunteered services and approximately 50 people per week have participated in this program in Lake County.

With the changing insurance regulation legislation in 1983 and 1984, concerns regarding HMOs, 1PAs, PPO systems and other reimbursement arrangements are surfacing. As a result, the Lake County Medical Society sponsored a program with representatives from major local industries and their insurance carriers to describe their changes in benefits and eligibility criteria. This was a well received liaison with all parties concerned and some 100 physicians attended.

The Tenth District Golf Outing was held at Briar Ridge Country Club in September with the meeting, followed by dinner, at Woodmar Country Club. Dr. Vincent J. Santare was elected Tenth District president, Dr. Charles D. Egnatz was re-elected trustee, and Dr. Walfred A. Nelson was re-elected alternate trustee. Mr. Dan Hill has accepted a position as executive director of Lake County Medical Society. Mr. Hill is an attorney, previously on the staff of the American Medical Association and the staff of the American College of OB-GYN.

The 1984 Tenth District meeting, which will have been held by this printing, is expecting Peter Visclosky, the Democratic candidate for U.S. Congress from the First District, as the guest speaker. This position is presently held by Katie Hall and previously held by the late Adam Benjamin.—Charles D. Egnatz, M.D., Trustee

## Thirteenth District ACTION:

The Thirteenth District Medical Society had their successful 1983 annual meeting at the Elcona Country Club in Elkhart. The meeting was fairly attended and the evening session was very well attended, with over 180 people at the meeting. It has been a problem to attract members of the district medical societies to attend the business meetings which are held at 5:30 in the afternoon.

Twelve years ago, Dr. Frank McGue, then president of the Thirteenth District

Medical Society, instituted a golf outing to attract the doctors early in the afternoon and entertainment in the evening to increase the attendance. This has worked out fairly well, but the attendance at the business meetings needs to be improved. It is at these meetings that we elect our district officers who represent physicians in the eight counties of the Thirteenth District at the state level.

Dr. Richard Green of South Bend was elected president for 1984 and Dr. B.V. Tiscay of Michigan City was elected president-elect for 1985. Dr. Don Chamberlain, our trustee for six years, retired and Dr. John W. Luce of Michigan City was elected trustee of the Thirteenth District Medical Society. Dr. Steven Yoder of Goshen was elected alternate trustee to fill the unexpired term until 1985.

This year's annual meeting will be held Sept. 12, 1984, at the Knollwood Country Club in South Bend. The St. Joseph County Medical Society will be the host society and activities are planned for the day including golf, spouses' programs, door prizes, dinner and a guest speaker.

of Trustees. One of the problems facing us was the deficit budget that was proposed by the Executive Committee. We have not had a dues increase since 1975 and we all know what inflation has done to the value of the dollar. With increased activities and operations, the State Medical Association has been able to hold the line in the budget with outside investments. In 1984, we are faced with a \$30,000 deficit budget and a dues increase will be proposed to the House of Delegates in October 1984.

Another problem that was resolved by the Indiana State Medical Association was the establishment of an Indiana PRO. This was mandated by the House of Delegates in 1983 and Dr. Muller's committee has been working hard on establishing its acceptance by the HCFA. The proposal, introduced by Indiana's PRO, was accepted on a basis that they amend some of the proposals to satisfy HCFA's regulations. Fifteen states have been denied PRO contracts because of their proposals, and it is hoped that this will be finalized by the Oct. 1, 1984 deadline for PROs. This will keep the

peer review of the DRGs in the hands of the physicians and not unqualified sources. It is hoped by the Board of Trustees that the physicians in the districts will cooperate with PRO and volunteer to sit on these panels for medical reviews. The funding of the Indiana PRO was done by the ISMA and it is hoped that we will recoup the start-up expenses which are in excess of \$60,000 this year from the monies that will be obtained by the PRO for their work.

Dr. George Lukemeyer, president of ISMA for 1984, has been an inspirational leader and has put many proposals on the table for the State Medical Association to implement. He has also been helped by the president-elect, Dr. Lawrence Allen of Anderson. With the coming of more federal regulations and DRGs even from the private insurance carriers, the physicians of the State Medical Association voted to endorse the AMA's physician fee freeze for 1984. Whether this will be effective or not remains to be seen. Placing the blame of inflation upon physicians' fees when the federal budget deficit is over \$200,000,000,000 is incongruous.

In 1984, I have instituted a policy of writing letters to all the eight county medical societies after each Board of Trustees meeting, informing the constituents as to what business took place at the Sunday meetings. I have also visited several of the county medical societies. giving them verbally first-hand information as to what happened in Indianapolis. Dr. Steven Yoder has also visited several of the county medical societies in the eastern part of the district doing the same thing. I intend to continue this policy of writing letters after each Board of Trustees meeting, as 1 feel the members of the Thirteenth District Medical Society should be up to date on what is happening in the Board of Trustees and Executive Committee of the State Medical Association.

I have enjoyed my first year as a full trustee. I am looking forward to cooperating with Dr. Larry Allen next year and the other members of the Board of Trustees. I hope to continue to have access to all members of the district.—John W. Luce, M.D., Trustee

Commission members are listed on p. 738.

Medical Education
Referred to: Ref. Comm. 4

ACTION:

The Commission on Medical Education met Nov. 20, 1983 and April 8, 1984. Dr. Shokri Radpour was named vice-chairman of the commission.

The major activity of the commission was that of the accreditation/reaccreditation process of hospitals and organizations for CME. During the year there were eight hospitals reaccredited for continuing medical education and 10 organizations reaccredited. One organization was granted its initial accreditation. One organization was denied accreditation and two organizations had their accreditation deferred for the need of additional information. In total there were 22 accreditation actions during the year.

The commission conducted its second annual Site Surveyors Workshop Nov. 19, 1983. The workshop included the study of the new ACCME Essentials for Continuing Medical Education with Guidelines and the suggested Pre-survey/ Survey document. Recommendations for changes were then made to the Commission on Medical Education.

The commission reviewed the Essentials, Guidelines, and the Pre-survey forms with the recommendations from the workshop and approved a corrected Essentials and Pre-survey form for ISMA use. The commission also reviewed the Protocol for Review and Recognition of State Medical Associations for use by the ACCME.

The commission reviewed recommendations to be made to the ACCME relative to the accreditation for intra-state CME offerings in order to eliminate the confusion relative to intra/inter state CME program accreditation. The recommendations were then forwarded to the ACCME for their consideration.

The commission nominated Dr. Eugene Gillum, chairman of the Subcommission on Accreditation, and Dr. Franklin A. Bryan, chairman of the Commission on Medical Education, as ACCME site visitors. The commission also nominated Dr. Franklin A. Bryan to be a member of the Committee on Review

and Recognition (CRR) of State Medical Associations of the ACCME.

Dr. Bryan was invited to attend the ACCME meeting in Chicago on June 7, 1984 as a guest. Dr. Bryan spoke regarding intra/inter state CME problems with recommended solutions to be presented at its next (ACCME) meeting. At the same meeting of the ACCME, Dr. Bryan was appointed as a member of the new Committee for Review and Recognition (CRR) of State Medical Associations. At the organizational meeting of this committee, he was selected for a three-year appointment.

The Subcommission on Accreditation met on the same dates as the commission just prior to the commission meetings. The chairman of this commission is Dr. Eugene Gillum, the vice-chairman, Dr. Kelley Chambers. The subcommission reviewed all of the accreditation/reaccreditation documents and made recommendations to the commission. The subcommission also reviewed the recommendations from the workshop relative to the new Essentials and Guidelines and the Pre-survey/Survey forms making recommendations to the commission on these documents also.

The chairman of the Commission on Medical Education wishes to acknowledge and express his appreciation for the activities of the subcommission, and thanks Dr. Gillum, Dr. Chambers, vicechairman, and members for their input into the continuing medical education activities of the ISMA. The chairman also wishes to acknowledge and express his appreciation for the activities of Dr. Radpour, the vice-chairman, and the members of the commission for their activity in CME accreditation for the ISMA. The site visitors are also recognized for their outstanding activity, without which the accreditation process could not be carried out.

Finally, the outstanding work and dedication of the ISMA staff member, Beckett J. Shady-King, without whom the subcommission and commission could not have functioned effectively, is recognized. The chairman for the commission wishes to express his deep apprecation.—Franklin A. Bryan, M.D., Chairman

#### Legislation

Referred to: Ref. Comm. 3 ACTION:

Your Commission on Legislation has been quite active throughout the past year. The activity seems to always pick up pace when the Legislature is in session. All the bills that had an impact upon the medical profession were discussed at length at a number of commission meetings during the winter and spring.

As your chairman, I spent a great deal of time at the Legislature. I had an opportunity to testify at the Generic Substitution Reference Committee on the House side. Through the efforts of your legislative lobby, Rick King and myself, a Generic Substitution Bill did evolve that contained all of the major provisions that the commission members felt were important for protection of the patient, the physician, and the pharmaceutical industry.

The Commission on Legislation was involved with the leadership of ISMA by impacting upon a bill that would have eliminated a physician from being commissioner of the State Board of Health. Final provisions of the bill did provide for the governor to appoint the commissioner, but the commissioner must be a licensed physician.

Numerous other bills were followed and lobbied throughout the legislative session. Licensing of athletic trainers, physical therapists, and other paramedical personnel were followed quite closely. Testimony was presented on numerous occasions representing ISMA's position.

Another exciting event has occurred and is continuing to evolve this year. The Commission on Legislation has met jointly with the IMPAC board. A very comprehensive program is being established for the fall of 1984. We have established the goal of visiting every county medical society from September through December in carrying the message for not only the Commission on Legislation, but the IMPAC board. It is our goal to have a commission member and an IMPAC board member at every county meeting. We recognize that this is quite ambitious, and we may fall short of our goal, but felt that it was important to set our standards high. We will

continue to maintain liaison with the IMPAC board.—Edward L. Langston, M.D., Chairman

# Sports Medicine Referred to: Ref. Comm. 4

**Referred to:** Ref. Comm. 4 **ACTION:** 

I am pleased to report that the ISMA Commission on Sports Medicine continues to progress and, in 1984, we have made a significant impact upon the medical care of Indiana's athletes.

The following summarizes the major highlights, listed in the order of their significance:

- 1. Elevation of the commission from an ad hoc organization to a standing commission.
- 2. A definitive statement defining the purpose of our commission, to be included in the ISMA bylaws.
- 3. During the fall football heat crisis of August 1983, the commission held emergency meetings and passed a set of guidelines to reduce further heat-related illnesses. The IHSAA instituted our recommendations with a reduction in incidents. Furthermore, we were able to help by recommending moving back the start of fall football in order to avoid the heat/humidity problems. By 1987, we hope to have football moved back to after September 1st, to avoid heat stress.
- 4. A panel of head and neck specialists recommended guidelines for the prevention and treatment of head and neck injuries. These suggested guidelines were distributed to team physicians, trainers and coaches.
- 5. Our recommendations to the IHSAA to discontinue the two-a-day basketball tournament format was presented to the IHSAA governing board and they have elected to change the regionals and sectionals to a Friday-Saturday format, but not the semi-finals or the state finals.
- 6. Our commission has *strongly* recommended implementing a plan to place a trainer in every high school by 1990. We propose setting up a postgraduate summer program for a designated teacher in each high school to educate this individual on training techniques. These teacher-athletic trainers (TATs) would be eligible after three summers' education,

to be certified as trainers and would be most beneficial in caring for Indiana's athletes. We propose that this be done through the Department of Public Instruction; however, we have not yet persuaded Dr. Negley of the impact that this would have in improving the "working" conditions of our athletes. We will be focusing our direction to proposing legislation to set up this teaching program. This is the most important advancement the ISMA Commission on Sports Medicine could undertake—that of providing each and every athlete the opportunity to work with such an individual in preventing injuries and medical complications.

7. The commission, under Dr. Phil Eskew's leadership, has revised the IHSAA Physical Form to update the contraindications to exercise and also to streamline the forms. Furthermore, the commission reiterated the position that IHSAA Physical Exams be performed by physicians practicing in Indiana with an unlimited license to practice medicine.

In summary, the ISMA Commission on Sports Medicine is progressing toward our goal—that of improving the medical care of our Indiana athletes and related personnel.

We feel a great advancement in the future of sports medicine in Indiana would be the inclusion of trainers in each participating high school. Then, we would feel we have reached the goal we set out to accomplish two years ago.

It has been a great honor to have served as chairman these past two years. I will look forward to helping the next chairman advance these goals.—Gary L. Prah, M.D., Chairman

#### **Public Relations**

Referred to: Ref. Comm. 5 ACTION:

The past year has seen some exceptional developments in ISMA's external public relations.

Heartbeat, the 13-segment series of half-hour television programs sponsored by the Association, was aired on 27 stations throughout the nation, including Public Broadcasting System affiliates from Florida to Alaska and Puerto Rico to Pennsylvania. Last spring, Heartbeat was honored by the International Asso-

ciation of Business Communicators with a first-place award in the Bronze Quill Awards Contest. The award is given for the best communications series and *Heartbeat* received top honors in the largest contest with the most entrants in the history of the competition.

Through the Commission on Public Relations, ISMA is taking an assertive, innovative step in shaping public attitudes toward physicians. While surveys demonstrate that patients admire and are satisfied with their personal physicians, the public attitude toward physicians in general is not so positive and there is evidence that negative attitudes and dissatisfaction are increasing. Because negative public attitudes create a climate which facilitates the development of such programs as prospective pricing, DRGs, mandatory assignment, and so on, the Commission on Public Relations has taken steps to change those attitudes. With approval and funding through the Board of Trustees, the commission has contracted with Holden & Co., a public relations and marketing firm specializing in the health care field, to launch a statewide public information and education campaign. Radio and newspapers advertisements and billboards are being utilized throughout the state to carry out the goal of the program—positioning the physician as the patient's advocate. All materials produced by Holden & Co. for the campaign are reviewed by a specially designated subcommittee of commission members.

Ongoing public relations programs such as *Your Hoosier Doctor Says*, the ISMA health tips column used by newspapers throughout Indiana, continue to be successful components of our community relations. The commission and PR staff have also been the liaison for involvement with organizations such as the American Lung Association, American Cancer Society and the Indiana Academy of Family Physicians.

Internal communications—ISMA Reports and Siebenmorgen's Notes—continue to keep the membership informed of events of interest both within and outside of the Association.

Once again, ISMA, through the recommendation of the Commission on Public Relations, contributed \$100 to the National Journalism Center to help train

responsible journalists.

Finally, the commission selected award winners among print and broadcast entries in the annual Journalism Awards competition as well as selecting a physician to be honored with the Physician Community Service Award.

I'd like to express my deep appreciation for the outstanding cooperation and efforts of each member of the Commission on Public Relations and the ISMA PR staff during the past year.—John V. Osborne, M.D., Chairman

#### Subcommission on Insurance Referred to: Ref. Comm. 4

Referred to: Ref. Comm. 4 ACTION:

Members of the Subcommission on Insurance met on Jan. 11, 1984 to negotiate the new health and dental insurance contract for ISMA members and their employees, to review the in-depth claim data provided by The Lincoln, make recommended changes to the program which could have a beneficial impact on premium stabilization and increase benefits to the participants, and to handle other insurance-related matters.

Although it is still too early to be optimistic about the changes approved by the Board of Trustees and incorporated in the 1984-85 health insurance program—insofar as premium stabilization is concerned—the monthly claim expense report for April, May and June show that we have been below our monthly dollar cap allotted to pay claims; and that is a good sign.

After careful review of all the data provided by The Lincoln, the subcommission recommended, and the Board approved, a six-month rate renewal which included a 33% increase for Plan 1, 14% increase for Plan 2, and a 25% increase for Plan 3. A new Plan 4 comprehensive major medical with a \$2,000 deductible (three per family), and 80% coinsurance to \$10,000 (\$30,000 maximum per family) per year was also approved. Plan 4 rates were set at 24% less than Plan 2 rates.

The reason for the six-month renewal was the Board approved going to age-banded rates starting Oct. 1, 1984. The subcommission was to review all the data and negotiate the new age-banded rates on July 25, 1984. It is anticipated, because

of the current claim experience, that the rates will be the same as those approved in January 1984.

Other actions taken by the subcommission, and approved by the Board, aimed at stabilizing future premium increases were: change the pre-existing limitation to read maximum \$1,000 benefit until 90 days without care or treatment or 24 months continuously insured for all new participants in the health insurance program; change the eligibility requirement for future participants to read, medical evidence of insurability required on all individuals and all groups with less than six lives; and that medical evidence of insurability be required of any individual or group with less than six lives who shift to a more liberal plan.

In addition, the Board approved modifying the mental and nervous benefit to read 42 days maximum hospital confinement per year, 92 professional visits per year (42 in-hospital and 50 out-patient), \$6,000 maximum payment per year for professional fees, include day/night care plus residential treatment services, and continue \$50,000 lifetime maximum for professional fees only; and change Plan 2 and Plan 3 benefits to include 100% payment for preadmission testing with no deductible, and 100% payment for outpatient surgery, no deductible, on a list of procedures approved by ISMA.

health and dental coverage to the surviving spouse of a non-covered member with evidence of insurability, and approved extending coverage for disabled and retired employees of ISMA members. The extension of benefit for disabled employees is: less than one year employment, two months extension; one to two years employment, one year extension; and more than two years employment, two years extension. The extension of benefit for retired employees is: age 55 with 15 years of service, extended benefits to include Medicare supplement.

The subcommission reviewed Resolution 83-25, Disability Insurance Form, at the Board's request, and agreed that a disability form regarding total and permanent disability should provide more work-related information for the attending physician to answer the question appropriately. Therefore, the subcommis-

sion recommended, and the Board agreed, that the resolution should be sent to the Health Insurance Association of America (HIAA) and to the ISMA Business/Medicine Coalition asking for their recommendations on how this could be accomplished. HIAA sent back a current copy of its disability form requesting ISMA's opinion as to whether or not it contained enough work-related information to satisfy ISMA's resolution. After reviewing the form, the subcommission sent H1AA a copy of the form it received from the Fort Wayne/Allen County Business/Medicine Coalition suggesting that it would make a good companion piece or addition to the HIAA form. HIAA has put the issue of modifying its standard claim form to reflect an employer evaluation of other jobs an individual might be eligible for in the company on the agenda for its next committee meeting.

Resolution 83-33, Medical Protective Company (Denial of renewal of liability insurance coverage) was also given to the subcommission for action by the Board. After reviewing the resolution the subcommission recommended, and the Board approved, sending a letter to the Indiana Insurance Commissioner requesting his opinion as to whether or not denial of renewal of liability insurance coverage without giving a reason is a violation of any law, rule or regulation. The response from the Insurance Commissioner's office was that a non-admitted or admitted insurer writing professional liability coverages in this state may refuse to renew a policy without giving prior notice or reason unless the contractual terms of the policy that they have previously issued state otherwise.

In addition to negotiating the new agebanded rates on July 25, the members of the Subcommission on Insurance will respond to The Lincoln's request for clarification of the new mental and nervous lifetime maximum; review Lincoln language on organ transplants for possible inclusion in the ISMA master contract; and review the Ontario Medical Association long-term disability insurance plan for possible recommendation to, and duplication by American Physicians Life for ISMA members.

The subcommission will always be

responsive to the members' needs and will continue to search the marketplace for the best programs available to meet those needs.

I want to thank the subcommission members who gave generously of their time and efforts and the ISMA staff for their excellent assistance.—John Mac-Dougall, M.D., Chairman

Subcommission members:

Garry Bolinger, M.D. William Cutshall, M.D. John Lanman, M.D. Francis Price, Jr., M.D. Dwight Schuster, M.D. John Thomas, M.D.

#### Physician Impairment Referred to: Ref. Comm. 3 ACTION:

The Commission on Physician Impairment matured in 1983/84, primarily in the clarification of our role in Indiana medicine and in expansion of the numbers of Indiana physicians knowledgeable about the general identification and management of impaired colleagues.

The commission was very much involved in the formulation of a second effort at rewriting Medical Licensing Board regulations. Fortunately, the new regulations which were signed into law by the Governor in April 1984 create a "diversionary path." An Indiana physician suffering impairment from drugs, psychiatric difficulties, senility, etc., may seek out and volunteer to cooperate with a duly authorized impaired physician committee at the local hospital, county society, or ISMA level, and as long as he is cooperating fully with the directives of the impaired physician group, he is immune from reporting to the Medical Licensing Board. This major change creates the positive situation wherein an impaired physician and/or hospital or colleagues find involvement with the impaired physician process to be preferable to other alternatives of management of such impairment.

In March 1984, the first Indiana Impaired Physician Commission-sponsored training seminar was conducted, with three national speakers including Dr. William Rial, immediate past president

of the AMA, and an attendance of over 100 members of the ISMA. The nature of physician impairment, its identification and management, as well as small group training in confrontation techniques, made the day very successful from the perspective of the attendees. In the process, the awareness of Indiana physicians of both impairment and its management seems to have significantly increased.

The commission is currently working on a new effort at confidential but effective record keeping of impaired physicians, in part to prevent "geographic cures" of impaired physicians moving from one location to another, and to allow more thorough and beneficial follow-up to impaired colleagues.

Overall, the activities of the commission seem to be steadily increasing, with consistently greater numbers of physicians with problems coming to our attention. As is so often the case with this kind of enterprise, our overall observations are that work has just begun.—Larry M. Davis, M.D., Chairman

#### **Medical Services**

Referred to: Ref. Comm. 4 ACTION:

The business of the ISMA Commission on Medical Services involves acting on actions mandated by the ISMA House of Delegates as well as interim issues referred by the ISMA Board of Trustees.

During fiscal year 1983-1984, the Commission met and acted on Resolution 83-1 (Foot Surgery) referred by the ISMA House of Delegates. The Commission noted that the Federal Trade Commission has placed constraints on professional associations. The Commission is therefore acting on this issue in a very deliberate fashion. At the present time, the Commission is meeting with ISMA legal counsel in an attempt to assure quality of care while at the same time avoiding any semblance of being in restraint of trade.

The Commission is also currently involved in studying the concept of ISMA establishing a fee review council to assist county medical societies in local fee review. Since this is another legally sen-

sitive issue, the Commission is working closely with ISMA legal counsel in an attempt to develop a legal mechanism for conducting voluntary fee review. Once these issues have been resolved, appropriate recommendations will be made to the ISMA Board of Trustees and/or House of Delegates.—John D. MacDougall, M.D., Chairman

#### Constitution & Bylaws Referred to: Ref. Comm. 2 ACTION:

The Commission on Constitution and Bylaws has met twice thus far in 1984. During these meetings the commission incorporated all bylaw amendments mandated by the 1983 House of Delegates into our current document. Again, our commission has been privileged to have total participation from its membership in a most active and efficient manner.

The Commission reviewed the Constitution and Bylaws of the Intern and Medical Resident Society and made recommendations to the Society regarding clarification of same.

The Commission is submitting resolutions calling for modifications that will assist ISMA commissions and committees in their activities. Please give the resolutions consideration and be assured that your Commission is diligently striving to fulfill its responsibilities as charged in the bylaws.

I wish to acknowledge the dedicated efforts of Ms. Beckett Shady-King and Ron Dyer, ISMA staff, without whose assistance our task would be hopeless.—Lloyd Hill, M.D., Chairman

#### **Reports of Committees**

Committee members are listed on p. 739.

#### **Future Planning**

Referred to: Ref. Comm. 5 ACTION:

I would like to express my appreciation to the members of my committee for their excellent attendance, along with support of staff which has been quite helpful and informative. I would like to thank Dr. Lukemeyer for challenging our committee in a number of important areas involving medicine today.

The Future Planning Committee has been involved in several areas. One has been the assessment of future practice environment. We have spent time discussing such areas as the New Jersey DRG experience and the number and distribution of physicians at present and in the future.

We spent considerable time evaluating the different staff responsibilities and the ISMA budget. After considerable evaluation, it was felt that certain staff changes would be indicated and job descriptions somewhat changed. The first area is that of the field representative and his job description. It is our feeling that field representatives are somewhat overburdened with a number of areas, that their duties should be more specifically defined and that this should be especially devoid of time-consuming legislative activity. We recommend that the field representatives be involved more with the local districts and counties, with their organization and operation, and with disseminating information to these local groups, as we feel communication is the most important area. Because the state, at times, does poorly communicate to its members, we feel that field staff activity involved in this area is quite important. Thus, we will maintain our two field representatives. but their involvement will be more in the local societies.

We also looked at the need for expanding our legislative staff, as we feel that legislation over the next one to two decades is going to be extremely important and many laws will be put into effect involving the practice of medicine. We feel that we should be involved in preventing many of these laws that will be not only adverse to physicians, but

adverse to our patients. Thus, we recommended that additional legislative staff be added. This was supported and two additional members will be involved in legislation drafting, etc.

It was also felt that much of what physicians do is not always imparted to our patients. We feel that further strengthening of our public relations staff is important so we have recommended the employment of an additional staff member.

We were also asked to evaluate the dues structure. It became quite obvious that a dues increase is necessary, as the expenses of operating the organization have increased considerably over the last eight to nine years and there has been no dues increase since 1975. The need for a dues increase was evaluated in detail and recommendations were made to the Board to have a dues increase in the next year to help improve our deficit budget.

As far as future involvement for the committee, we have two areas in particular that we will be addressing. One will be the district meetings and their success. It has been noted in the last four to five years that attendance at district meetings has been down and, in many instances, that most of the physicians in attendance are officers from the Indiana State Medical Association. A smaller number are the local physicians. The Future Planning Committee will study the structure of the district meetings and make recommendations to the Board as to whether they be continued in the same pattern, or if necessary changes need to be made to improve the effectiveness of these meetings.

The committee also has been studying future office space options; a subcommittee has been appointed and is currently studying this particular problem. Office space has been in the process of being evaluated for the last eight to 10 years and, up to this date, no concrete recommendation can be made to the Board. We hope that our committee will have some type of recommendation by the end of this year for future space options.

Again, I would like to express my appreciation to the committee and staff for their support thus far for the Future Planning Committee.—William C. VanNess II, M.D., Chairman

#### Grievance

Referred to: Ref. Comm. 5 ACTION:

The Grievance Committee met during 1984 and reviewed approximately 10 cases, several of which are still pending.

As usual, the lack of good patient communication has been the source of most of the complaints that the committee has received. As chairman, 1 wish to thank the two other members of the committee for their attendance and valuable assistance during the year.—G. Beach Gattman, M.D., Chairman

#### Medical Education Fund Referred to: Ref. Comm. 4 ACTION:

Representatives from the Trust Department of the American Fletcher National Bank, Mr. Fran Brezette and Mr. Larry Cole, met with the Indiana Medical Education Fund Committee in May 1984. A review of the portfolio's performance was presented. It was estimated that the portfolio could double in value within six years, assuming 12% interest and excluding contributions and distributions.

The AMA-ERF provided \$74,375.89 for the Indiana University School of Medicine in 1984. Prior contributions have been: 1983—\$66,489.88, 1982—\$59,372.97, 1981—\$55,556.83, 1980—\$48,476.18.

Distributions made to the Indiana University School of Medicine for 1983 and 1984 provided funding for the Research Scholars program and the Research Fellowship program.

The committee again wishes to acknowledge the fine work of the Auxiliary in raising money for this fund.

many in raising money re-	
Fund Balance: 7-1-83	\$534,110.30
1983 Distribution to Indiana	
University School of Medicine	(-60,000.00)
1984 Distribution to Indiana	
University School of Medicine	(-60,000.00)
AMA-ERF Contribution	74,375.89
James A. Harshman, M.D.	
Memorial Fund	2,245.00
Trustee Fees	(-2,000.51)
Interest Income	39,274.16
Net Realized Gains	44.19
Fund Balance: 6-30-84	\$528,049.03
I tilla Dalance. 6 30 64	\$520,015.05

-John W. Beeler, M.D., Chairman

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#### **Reports of Committees**

#### Reduce Drunk Driving Referred to: Ref. Comm. 5 ACTION:

Resolution 83-3, passed by the 1983 House of Delegates, created an ISMA Reduce Drunk Driving Committee. The established goal of the committee is to reduce deaths and injuries due to drunk driving by 50% during the next five years and by an additional 25% during the following five years. The committee was recognized for its efforts in working toward this goal in the Dec. 2, 1983 issue of the *American Medical News*.

The committee has worked closely with the Governor's Task Force to Reduce Drunk Driving in accomplishing this goal. Mr. Stephen Goldsmith, chairman of the Task Force, recently stated, "I think the teamwork between the Medical Association and law enforcement authorities has been, in part, directly responsible for the reduced number of deaths and injuries from drunk drivers."

The Reduce Drunk Driving Committee currently is diligently seeking funding in order to wage a statewide television blitz against drunk driving. It is planned that these commercials will be aimed at all ages of drivers. Additionally, the chairman of the committee participated with Governor Robert Orr and Senator Dan Quayle in the Hoosiers Against Drunk Driving Conference held in Indianapolis, Aug. 31-Sept. I, 1984. According to Governor Orr, "HADD will launch a model statewide thrust for high school students and adults who wish to prevent drunk driving and we believe it will be the first effort of this kind held in the nation."

I wish to express my appreciation to the many individuals who have contributed their expertise in addition to the dedication of the committee members in an effort to accomplish our goal.— Michael B. DuBois, M.D., Chairman

#### Ad Hoc Malpractice Advisory Committee Referred to: Ref. Comm. 4 ACTION:

The Ad Hoc Advisory Malpractice Committee met on several occasions during 1984 and monitored closely the legislative efforts during the 1984 session of the Indiana State Legislature.

Meetings with the Insurance Commissioner of the State of Indiana and both defense and plaintiff attorneys have confirmed the fact that the Patients Compensation Fund established under the Malpractice Act has been invaded for sums of money to pay claims to an extent which had not been anticipated. This has seriously jeopardized the integrity of the Patients Compensation Fund and necessitated a 50% surcharge on malpractice premiums to prevent the fund from becoming financially insolvent.

Various methods have been discussed to protect the essential features of the Malpractice Act and the fiscal responsibility of the Patients Compensation Fund. Ongoing conferences with the insurance industry, the Insurance Commissioner, the legal profession and the medical profession will hopefully lead to a consensus about what actions can be taken to retain the necessary features of the Malpractice Act. Such recommendations will be passed on to the president and Board of the Indiana State Medical Association for their consideration and action. If adopted by the ISMA as official policies, these views will be presented to the Legislative Commission established by the last legislature.—J. William Wright Jr., M.D., Chairman

#### Ad Hoc Committee on Student Representation in the House of Delegates

Referred to: Ref. Comm. 2 ACTION:

In 1983, the convention charged that a recommendation be made in 1984 regarding student representation (number of delegates) in the ISMA House of Dclegates. A committee representing the ISMA leadership, students and various geographical locales of Indiana was named by the ISMA president, Dr. George Lukemeyer. In initial committee meetings, it became readily apparent that a more crucial issue existed than even student representation with the House of Delegates—that being lack of a formally organized student constituency group. In this regard, the committee, through aid

of the ISMA staff, reviewed organizational charters and numerical representation of student societies in other state associations. The ad hoc ISMA committee met with ISMA student representatives and student government representatives in this regard on several occasions.

Currently, the medical student government and the ISMA student representatives have formed a task force to formally establish an ISMA student organization which will be representative of all student ISMA members. Technical assistance and advisory consultation will be provided by the ISMA staff and the ad hoc committee. The student task force recommendation will be reviewed by the Indiana University School of Medicine student government and presented to the ad hoc ISMA committee this fall. At that time, the ad hoc committee will analyze all material presented and make its final recommendations to the House .-William H. Beeson, M.D., Chairman

## Ad Hoc Geriatrics Committee

Referred to: Ref. Comm. 5 ACTION:

The ad hoc Geriatrics Committee, appointed in February 1984, met once so far in 1984 to discuss medical care for the aged and how to establish better communications with senior citizens.

Resolution 83-31, Physician Patient Visits at Nursing Homes Conflicting with Inspection Protocol at the State Board of Health, Medicare, and Medicaid Inspection Teams; Resolution 83-35, Alternatives to Nursing Home Care; and Resolution 83-36, State Board of Health Regulations on Nursing Homes; were reviewed by the ad hoc Geriatrics Committee at the Board of Trustees' request.

After reviewing Resolution 83-31, it was pointed out that the Indiana State Board of Health is not in a position, nor does it have the authority, to make changes in the certification process as called for by this resolution. Therefore, the ad hoc committee sees no resolution to this problem at this time, and hopes the study by the Institute of Medicine will give some insight and guidance to this area of conflict between state and federal regulations.

#### **Reports of Committees**

The committee reported to the Board of Trustecs that it felt the Department of Public Welfare action requiring preadmission screening for patients entering nursing homes to determine if such placement was medically necessary satisfied the major concern of Resolution 83-35. However, the committee has some special concerns about the quality and cost effectiveness of home health care and fears that the public may bear the burden of this expense. They also fear that the Diagnosis Related Groups (DRGs), which limit the patient's time in the hospital, will eventually work their way into the nursing homes and result in premature movement of patients out of nursing homes and into home health care or custodial care. The committee feels that

the first priority of any determination of need program should go to existing agencies supplying home health care service.

The committee agreed with the intent of Resolution 83-36, presented to the ISMA House of Delegates by the DeKalb County Medical Society, but noted the law regarding sanctions and fines is not subject to change by rule or regulation of the Health Facilities Council. The committee believes the new regulations will respond to this resolution, but sent a copy to the DeKalb County Medical Society for their review and comments.

Report D of the AMA Board of Trustees, Health Care for an Aged Population, was discussed, along with the need for better communications with senior citizens. The committee recommended

that the ISMA president send a letter to the county medical society presidents asking them to designate one or two physician members from their society who would be willing to meet with senior citizen groups in their area to discuss such topics as cost of medical care, rationing of medical care, DRGs, and other medical related topics.

In addition, the committee is setting up a meeting with Maurice Endwright, president of the Indiana Federation of Older Hoosiers, and other key contacts from this group to discuss and exchange ideas related to geriatrics and the above topics.

I wish to thank members of the ad hoc Geriatrics Committee for taking their time to review these issues.-Bill L. Martz, M.D., Chairman

WHY AMA? Commitment to maintaining high quality at all levels of medical education is one of the AMA's proudest traditions. The AMA creates policy for medical education, participates in accreditation activities. and supplies the public with information on medical education issues. Proven dedication to high standards in medical education: it's one more good reason why you should be a part of the AMA.

WHY AMA? Now, for the first time there's a forum for hospital medical staffs to meet nationally to discuss common problems and changes in physician-hospital relationships. The Hospital Medical Staff Section was recently created by the AMA to provide leadership in ensuring quality patient care during this period of massive hospital restructuring. It's one more good reason why you should be a part of the AMA. To Join, Contact your county or state medical society or write: Division of Membership,

AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.



# Presidents of ISMA Since Its Organization

	Medical Convention	Elected	Served		Elected	Served
	*Livingston Dunlap, Indianapolis	1849	1849	*A. C. Kimberlin, Indianapolis.	1912	1913
	Elvingston Sumap, mananapons			*John P. Salb, Jasper	1913	1914
	Medical Society			*Frank B. Wynn, Indianapolis .	1914	1915
	*William T.S. Cornett, Versailles	1849	1850	*George F. Keiper, Lafayette	1915	1916
	*Ashahel Clapp, New Albany	1850	1851	*John H. Oliver, Indianapolis	1916	1917
	*George W. Mears, Indianapolis	1851	1852	*Joseph Rilus Eastman, Indianapolis.	1917	1918
	*Jeremiah H. Brower, Lawrenceburg	1852	1853	*William H. Stemm, North Vernon	1918	1919
	*Elizur H. Deming, Lafayette	1853	1854	*Charles H. McCully, Logansport	1919	1920
	*Madison J. Bray, Evansville	1854	1855	*David Ross, Indianapolis	1920	1921
	*William Lomax, Marion	1855	1856	*William R. Davidson, Evansville	1921	1921
	*Daniel Meeker, LaPorte	1856	1857	*Charles H. Good, Huntington	1921	1922
	*Talbot Bullard, Indianapolis	1857	1858			
	*Nathan Johnson, Cambridge City	1858	1859	*Samuel E. Earp, Indianapolis	1923	1924
	*David Hutchinson, Mooresville	1859	1860	*Eldridge M. Shanklin, Hammond.	1924	1925
	*Benjamin S. Woodworth, Ft. Wayne	1860	1861	N. H. J. A		
	*Theophilus Parvin, Indianapolis	1861	1862	Medical Association	1025	1026
	*James F. Hibberd, Richmond	1862	1863	*Charles N. Combs, Terre Haute	1925	1926
	*T-1 - Cl N A II	1863		*Frank W. Cregor, Indianapolis	1926	1927
	*John Moffett (acting), Rushville	1863	1864	*George R. Daniels, Marion	1926	1928
				*Charles E. Gillespie, Seymour	1927	1929
	*Samuel L. Linton, Columbus	1864	1045	*Angus C. McDonald, Warsaw	1928	1930
	*Wilson Lockhart (acting), Danville	1864	1865	*Alois B. Graham, Indianapolis	1929	1931
	*Myron H. Harding, Lawrenceburg	1865	1866	*Franklin S. Crockett, Lafayette	1930	1932
	*Vierling Kersey, Richmond	1866	1867	*Joseph H. Weinstein, Terre Haute	1931	1933
	*John S. Bobbs, Indianapolis	1867	1868	*Everett E. Padgett, Indianapolis	1932	1934
	*Nathaniel Field, Jeffersonville	1868	1869	*Walter J. Leach, New Albany	1933	1935
	*George Sutton, Aurora	1869	1870	*Roscoe L. Sensenich, South Bend	1934	1936
	*Robert N. Todd, Indianapolis	1870	1871	*Edmund D. Clark, Indianapolis	1935	1937
	*Henry P. Ayres, Ft. Wayne	1871	1872	*Herman M. Baker, Evansville	1936	1938
	*Joel Pennington, Milton	1872	1873	*Edmund M. Van Buskirk, Ft. Wayne.	1937	1939
	*Isaac Casselberry, Evansville	1873		*Karl R. Ruddell, Indianapolis	1938	1940
П	*Wilson Hobbs (acting), Knightstown	1873	1874	*Albert M. Mitchell, Terre Haute	1939	1941
	*Richard E. Houghton, Richmond	1874	1875	*Maynard A. Austin, Anderson	1940	1942
	*John H. Helm, Peru	1875	1876	*Carl H. McCaskey, Indianapolis	1941	1943
	*Samuel S. Boyd, Dublin	1876	1877	*Jacob T. Oliphant, Farmerburg	1942	1944
	*Luther D. Waterman, Indianapolis	1877	1878	*Nelson K. Forster, Hammond	1943	1945
	*Louis Humphreys, South Bend	1878		*Jesse E. Ferrell, Fortville	1944	1946
	*Benji. Newland (acting), Bedford (v.p.)	1878	1879	*Floyd T. Romberger, Lafayette	1945	1947
	*Jacob R. Weist, Richmond	1879	1880	*Cleon A. Nafe, Indianapolis	1946	1948
	*Thomas B. Harvey, Indianapolis	1880	1881	*Augustus P. Hauss, New Albany	1947	1949
	*Marshall Sexton, Rushville	1881	1882	*C. S. Black, Warren	1948	1950
и.	*William H. Bell, Logansport	1882	1883	*Alfred Ellison, South Bend	1949	1951
ш	*Samuel E. Mumford, Princeton	1883	1884	*J. William Wright, Indianapolis	1950	1952
н	*James H. Woodburn, Indianapolis	1884	1885	*Paul D. Crimm, Evansville	1951	1953
В.	*James S. Gregg, Ft. Wayne	1885	1886	*Wm. Harry Howard, Hammond	1952	1954
М	*General W. H. Kemper, Muncie	1886	1887		1953	1955
н	*Samuel H. Charlton, Seymour	1887	1888	*Walter L. Portteus, Franklin		1956
ш	*William H. Wishard, Indianapolis	1888	1889		1954	1957
B	*James D. Gatch, 1.awrenceburg	1889	1890	*Elton R. Clarke, Kokomo	1955	
1	*Gonsolvo C. Smythe, Greencastle	1890	1891	M. C. Topping, Terre Haute	1956	1958
	*Edwin Walker, Evansville	1891	1892	Kenneth L. Olson, South Bend	1957	1959
A	*George F. Beasley, Lafayette	1892	1893	*Earl W. Mericle, Indianapolis	1958	1960
1	*Charles A. Daugherty, South Bend	1893	1894	*Guy A. Owsley, Hartford City	1959	1961
	*Elijah S. Elder, Indianapolis	1894	1094	*Harry R. Stimson, Gary	1960	1962
H	*Charles S. Bond (acting), Richmond	1894	1895	Maurice E. Glock, Fort Wayne	1961	1963
		1895	1895	Donald E. Wood, Indianapolis	1962	1964
	*Miles F. Porter, Ft. Wayne	1895	1896	Joseph M. Black, Seymour	1963	1965
1	*William N. Wishard, Indianapolis	1897	1897	*Kenneth O. Neumann, Lafayette	1964	1966
в	*John C. Sexton, Rushville			*Eugene S. Rifner, Van Buren	1965	1967
	*Walker Schell, Terre Haute	1898 1899	1899 1900	*G. O. Larson, LaPorte	1966	1968
18				Patrick J. V. Corcoran, Evansville	1967	1969
	*George W. McCaskey, Ft. Wayne	1900	1901	Lowell H. Steen, Hammond	1968	1970
Ш	*Alembert W. Brayton, Indianapolis	1901	1902	Malcolm O. Scamahorn, Pittsboro	1969	1971
	*John B. Berteling, South Bend	1902	1903	Peter R. Petrich, Attica	1970	1972
	*Jonas Stewart, Anderson	1903	1904	James H. Gosman, Indianapolis	1971	1973
11	*George T. MacCoy, Columbus	1904	1905	Joe Dukes, Dugger	1972	1974
1	*George H. Grant, Richmond	1905	1906	Gilbert M. Wilhelmus, Evansville	1973	1975
	*George J. Cook, Indianapolis	1906	1907	Vincent J. Santare, Munster	1974	1976
1	*David C. Peyton, Jeffersonville	1907	1908	John W. Beeler, Indianapolis	1975	1977
	*George D. Kahlo, French Lick	1908	1909	*Eli Goodman, Charlestown	1976	1978
1	*Thomas C. Kennedy, Shelbyville	1909	1910	*James A. Harshman, Kokomo	1977	1978
1	*Frederick C. Heath, Indianapolis	1910	1911	Arvine G. Popplewell, Indianapolis	1978	1980
	*William F. Howat, Hammond	1911	1912	Alvin J. Haley, Carmel	1979	1981
				Martin J. O'Neill, Valparaiso	1980	1982
				John A. Knote, Lafayette	1981	1983
1	*Deceased			George T. Lukemeyer, Indianapolis	1982	1984

## THE CONSEQUENCES CAN BE LIFE-SHORTENING.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease...diabetes...hypertension... congestive heart failure...an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight—if, in fact, it is ever achieved.

The Institute for Health Maintenance (IHM) can help.

Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss:

THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long-term behavioral and nutritional training.

Under the supervision of the IHM medical staff, patients lose weight safely and consistently over a period of weeks and months. They receive their total daily nutritional requirements from a low-calorie egg albumen formulation and a multivitamin tablet... a supplement they stay with until goal weight is achieved.

The success of the RFO Program has been significant.

Over the past five years, thousands of patients have lost from 25 to over 100 pounds, with the average loss being 63 pounds. More important, 75%\* of these patients have been able to sustain their new low weight levels with the help of our 18-month maintenance program.

Some have called the RFO Program "lifesaving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors-



one we at IHM can help control.

To learn more about us and how this program can safely benefit some of your patients, please contact one of our medical directors at a clinic near you.

\*Data on file, Institute for Health Maintenance.

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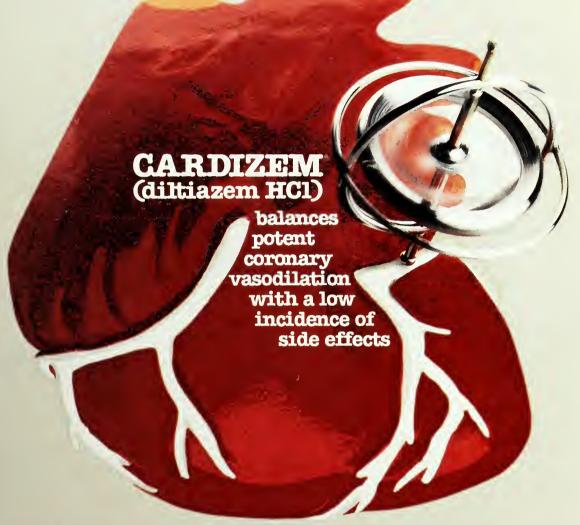
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# BALANCED CALCIUM CHANNEL BLOCKADE!



#### Low incidence of side effects

CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

#### References

- Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
- Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exerciseinducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

#### Reduces angina attack frequency\*

42% to 46% decrease reported in multicenter study.

#### Increases exercise tolerance\*

In Bruce exercise test, control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes (P < .005).

# CARDIZEM

(diltiazem HCl)

THE BALANCED
CALCIUM CHANNEL BLOCKER

#### PROFESSIONAL USE INFORMATION



DESCRIPTION

CARDIZEM\*\* (diltrazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically dittazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) ·5-[2-(dimethylaminolethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis- The chemical structure is

Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chlorotorm It has a molecular weight of 45D.98. Each tablet of CARDIZEN contains either 3D mg or 6D mg diltiazem hydrochloride for oral administration

#### **CLINICAL PHARMACOLOGY**

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed

and supplied actions are still believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced cor-

onary artery spasm are inhibited by CARDIZEM.

2. Exertional Angina CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interteres with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses. In man, dilitazem prevents spontaneous and ergonovine-provoked

coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection traction, and left ventricular and disastolic pressure have not been affected. There are as yet few data on the interaction of dilitazem and beta-blockers. Resting heart rate is usually unchanged as clightly reduced by difference.

of diluzem and beta-blockers. Hesting hear rate is usually unchanged or slightly reduced by diltiazem. Intravenous dilitiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective retractory periods approximately 20%. In a study involving single oral doses of 30D mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Dilitiazem associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients

more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about BD% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to BD% bound to plasma proteins Competitive ligand binding studies have also shown CARDIZEM inding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, altered by therapeutic concentrations of digoxin, hydrochlorothizatie, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life tollowing single or multiple drug administration is approximately 3.5 tollowing single or multiple drug administration is approximately 3.5 hours. Desacetyl diffuzem is also present in the plasma at levels of 1D% to 2D% of the parent drug and is 25% to 5D% as potent a coronary vasodilator as diffuzem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 20D ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given, a 12D-mg dose gave blood levels three times that of the 6D-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diffuzem.

#### INDICATIONS AND USAGE

Angina Pectoris Due to Coronary Artery Spasm. CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

2 Chronic Stable Angina (Classic Effort-Associated Angina). CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance. There are no controlled studies of the effectiveness of the concomitant use of dilitazem and beta-blockers or of the safety of this

combination in patients with impaired ventricular function or conduc-

#### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 9D mm Hg systolic).

#### WARNINGS

 Cardiac Conduction. CARDIZEM prolongs AV node retrac-tory periods without significantly prolonging sinus node recov-ery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly) in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystote (2 to 5 seconds) atter a single dose of 60 mg of dilitiazem.

Congestive Heart Fallure. Although dilitiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic

studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients. with impaired ventricular function is very limited. Caution should

be exercised when using the drug in such patients.

3. Hypotension. Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic

4. Acute Henatic Injury. In rare instances, natients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. See PRECAUTIONS and ADVERSE REACTIONS.

#### **PRECAUTIONS**

General. CARDIZEM (diltiazem hydrochloride) is extensively metab-olized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In sub-acute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and special studeum repairs studies, field toses of 1/2 mly/kg alm, higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Orug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM (See

Controlled and uncontrolled domestic studies suggest that con-comitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from tive to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 2D times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore

use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Satety and effectiveness in children have not

#### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricufar function and cardiac conduction abnormalities have usually been

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies

which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their trequency of presentation, are: edema (2.4%).

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1 asthenia (1.2%), AV block (1.1%). In addition, the following ev were reported infrequently (less than 1%) with the order of presi tion corresponding to the relative frequency of occurrence

Flushing arrhythmia, hypotension, brad

dia, palpitations, congestive heart fai

syncope.
Paresthesia, nervousness, somnole tremor, insomnia, hallucinations, and amn Constipation, dyspepsia, diarrhea, vom mild elevations of alkaline phosphatase, \$

SGPT, and LDH Pruritus, petechiae, urticaria, photosensi

Dermatologic: Other Polyuria, nocturia

The following additional experiences have been noted: A patient with Prinzmetal's angina experiencing episod vasospastic angina developed periods of transient asympto asystole approximately tive hours after receiving a single & dose of CARDIZEM.

dose of CARDIZEM. The following postmarketing events have been reported quently in patients receiving CARDIZEM, erythema multiform; kopenia; and extreme elevations of alkaline phosphatase. SGPT, LDH, and CPK, However, a definitive cause and effect be these events and CARDIZEM therapy is yet to be establisher.

#### **OVERDOSAGE OR EXAGGERATED RESPONSE**

Overdosage experience with oral diltiazem has been li Single oral doses of 300 mg of CARDIZEM have been well tole by healthy volunteers. In the event of overdosage or exagging response, appropriate supportive measures should be employed. addition to gastric lavage. The tollowing measures may be consi

High-Degree AV

Bradycardia

Hypotension

Nervous System:

Gastrointestinal

is no response to vagal blockade, admisoproterenol cautiously. Treat as for bradycardia above. Fixed degree AV block should be treated wi

Administer atropine (0.60 to 1.0 mg). I

diac pacing Administer inotropic agents (isoprote Cardiac Failure dopamine, or dobutamine) and diuretics Vasopressors (eg. dopamine or levari bitartrate)

Actual treatment and dosage should depend on the severifical situation and the judgment and experience of the t

clinical situation and the judgment and experience of the aphysician.
The oral/LD<sub>50</sub>'s in mice and rats range from 415 to 740 and from 560 to 810 mg/kg, respectively The intravenous LI these species were 60 and 38 mg/kg, respectively. The oral dogs is considered to be in excess of 50 mg/kg, while lethal seen in monkeys at 360 mg/kg. The toxic dose in man is not but blood levels in excess of 800 ng/ml have not been assimilated to the control of the con with toxicity

#### **DOSAGE AND ADMINISTRATION**

DUSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atheroscierotic nary Artery Disease or Angina Pectoris at Rest Due to nary Artery Spasm. Dosage must be adjusted to each pineeds. Starting with 3D mg four times daily, before meals bedtime, dosage should be increased gradually igiven in doses three or four times daily) at one- to two-day intervolptimum response is obtained. Although individual patier, respond to any dosage level, the average optimum dosag appears to be 18D to 240 mg/day. There are no available data in ind dosage requirements in day; There are no available data in individual or requirements in patients with impaired renal or ing dosage requirements in patients with impaired renal or inction. If the drug must be used in such patients, titrations carried out with particular caution.

- arried out with particular caution.

  Concomitant Use With Other Antianginal Agents:

  1. Sublingual NTG may be taken as required to about an anginal attacks during CARDIZEM therapy

  2. Prophylactic Nitrate Therapy CARDIZEM may be coadministered with short- and long-acting nitrates, the have been no controlled studies to evaluate the another combination.

  3. Beta-blockers. (See WARNINGS and PRECAUTIONS.)

#### **HOW SUPPLIED**

Cardizem 3D-mg tablets are supplied in bottles of 1 MD 0D8B-1771-47) and in Unit Dose Identification Paks of 1 DDBB-1771-49). Each green tablet is engraved with MARIO side and 1771 engraved on the other CARDIZEM 60-m atablets are supplied in bottles of 10D (NDC DDBB-1772-47) a Dose Identification Paks of 1DD (NDC DDBB-1772-49). Ea tablet is engraved with MARION on one side and 1772 on Issuer 1/8

Another patient benefit product from



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# OBITUARIES.

# Tom G. Sheller, M.D.

Dr. Sheller, 73, a retired Logansport psychiatrist, died June 8 at Logansport Memorial Hospital.

He was a 1942 graduate of Indiana University School of Medicine and was an Army veteran of World War 11.

Dr. Sheller retired in 1973 as psychiatrist for Logansport State Hospital, where he had worked 17 years.

# Richard R. Horswell, M.D.

Dr. Horswell, 54, a Lafayette physician, died May 26 at St. Elizabeth Hospital, Lafayette.

He was a 1955 graduate of Northwestern University Medical School, Chicago.

Dr. Horswell had worked at the Arnett Clinic in Lafayette since 1961; he practiced internal medicine with a subspecialty in gastroenterology. He was a member of the American College of Physicians and was certified by the American Board of Internal Medicine.

# James D. Lukins, M.D.

Dr. Lukins, 40, a family physician who formerly practiced in Jeffersonville and Salem, died June 30 at his home in Salem.

He was a 1976 graduate of Indiana University School of Medicine.

Dr. Lukins had been the team doctor for Jeffersonville High School. He had served his family practice residency at St. Francis Hospital, Indianapolis.

# Lowell W. Painter, M.D.

Dr. Painter, 77, a Winchester surgeon, died June 21 at Randolph County Hospital.

He was a 1930 graduate of Indiana University School of Medicine.

Dr. Painter was a former president of the Randolph County Medical Society and a long-time ISMA delegate representing Randolph County. He was a member of the ISMA Fifty Year Club and belonged to the American Academy of Family Physicians and the American Society of Abdominal Surgeons. He was a former Randolph County Hospital chief of staff and was one of the organizers of the Randolph County Nursing Home.

# George M. Jewell, M.D.

Dr. Jewell, 69, a retired Kokomo physician, died May 27 at St. Joseph Memorial Hospital of Kokomo.

He was a 1940 graduate of Indiana University School of Medicine and had served with the Public Health Service from 1940 to 1946.

Dr. Jewell was a past president of the Howard County Medical Society and the 11th Medical District. He was a member of the American College of Allergists, and the American Academy of Allergy and Immunology. He also was an artist, and several of his works are part of the permanent collection of Indiana University-Kokomo.

# Memorials: Indiana Medical Foundation

The Indiana Medical Foundation, Inc. was formed by the Indiana State Medical Association "for religious, charitable, scientific, literary or educational purposes." It provides financial assistance to support the educational mission of Indiana Medicine.

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# Duncan M. Shields, M.D.

Dr. Shields, 60, a retired occupational medicine specialist, died July 10 at his home in Chesterton.

He received the M.D. degree in 1947 from the University of Toronto.

Dr. Shields was the medical director at Bethlehem Steel Corporation's Burns Harbor Works from 1965 until his retirement in 1981. He was a member of the Industrial Medical Association and the American Academy of Occupational Medicine. He was certified by the American Board of Preventive Medicine.

# Chet K. Lamber, M.D.

Dr. Lamber, 75, a retired Indianapolis surgeon, died July 28 at Wishard Memorial Hospital.

He was a 1935 graduate of Indiana University School of Medicine and was a World War II Army veteran. He later retired as a colonel from the Army Reserves.

Dr. Lamber, originally from LaPorte, had a private practice until 1978 when he became plant physician for the RCA Corp. He was a member of the American College of Surgeons and the American Society of Abdominal Surgeons.

# Daniel M. Hare, M.D.

Dr. Hare, 67, a retired Evansville urologist, died Aug. 13 at Deaconess Hospital, Evansville.

He was a 1940 graduate of Indiana University School of Medicine and was an Army veteran of World War II.

Dr. Hare, a member of the American Urological Association and a diplomate of the American Board of Urology, retired in 1975. He was a former medical education director of St. Mary's Medical Center and a former president of the medical staff, Welborn Memorial Hospital. He was active in county and state medical affairs and was a former 1SMA delegate representing the Vanderburgh County Medical Society.

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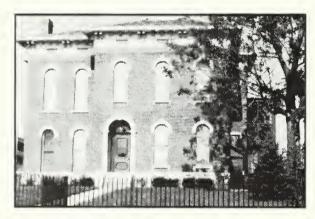
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# Simple Febrile Seizure

CONTINUED FROM PAGES 673-675

- 1. Simple febrile seizures occur during which of the following?
  - a. Neonatal period (the first month of life)
  - b. Pre-school period (1-6 years of age)
  - c. School-age period (6-12 years of age)
  - d. Adolescence (13-18 years of age)
- 2. Which of the following statements is *not* true of simple febrile seizures?
  - a. Inherited as a X-linked trait
  - b. More common in males than females
  - c. May be a manifestation of cerebral immaturity
  - d. Occurrence of the first simple febrile seizure is rare prior to 1 year of age or after 3 years of age
- 3. Which of the following is not characteristic of children with simple febrile seizures?
  - a. Less than 6 years of age
  - b. Otherwise normal without any neurologic deficit
  - c. 2-4% of pre-school children experience simple febrile seizures
  - d. An EEG 1-2 weeks following a sim-

- ple febrile seizure should be abnormal
- 4. Which of the following is true of the fever which triggers a simple febrile seizure?
  - a. Any temperature above 99.5 °F may trigger a simple febrile seizure
  - b. The source of the fever must be non-CNS in origin
  - Rapidity of rise in temperature is always a contributory factor in simple febrile seizures
  - d. The source of the fever is exclusively of bacterial origin
- 5. Which of the following is *not* characteristic of a simple febrile seizure?
  - a. The seizure occurs early in the febrile period
  - b. The seizures are primarily generalized
  - c. The seizures are of short duration
  - d. Recurrence within 24 hours is
- 6. Febrile seizures are characteristically
  - a. Focal
  - b. Generalized

- c. Petit mal
- d. Psychomotor
- 7. The most important part in the work-up of a simple febrile seizure is
  - a. A CAT scan
  - b. The history and physical
  - c. An EEG
  - d. A lumbar puncture
- Factors which place a child at risk for developing non-febrile seizures include all of the below except
  - a. A family history of febrile seizures
  - b. A previous neurologic deficit
  - c. Focal seizure activity
  - d. The first febrile seizure occurring prior to 1 year of age or after 3 years of age
- 9. Which of the following by itself would be an indication for anti-convulsant therapy in a child with a febrile seizure?
  - a. An EEG showing an epileptogenic focus
  - b. Two or more febrile seizures within a single febrile illness (24 hrs)
  - c. Two or more febrile seizures during the pre-school period
  - d. A family history of non-febrile seizures
- 10. Which of the following is the anticonvulsant of choice if treatment of a febrile seizure is indicated?
  - a. Dilantin
  - b. Phenobarbital
  - c. Valproic acid
  - d. Tegretol

# AUGUST CME QUIZ Answers

Following are the answers to the CME quiz that appeared in the August 1984 issue: "Aspiration Biopsy Cytology: Biopsy Method of the Eighties," By Michael D. Glant, M.D.

- 1. d 6. c 2. c 7. c 3. d 8. d 4. c 9. c 5. d 10. a
- Answer sheet for Quiz: (Simple Febrile Seizure)

 1. a b c d
 6. a b c d

 2. a b c d
 7. a b c d

 3. a b c d
 8. a b c d

 4. a b c d
 9. a b c d

 5. a b c d
 10. a b c d

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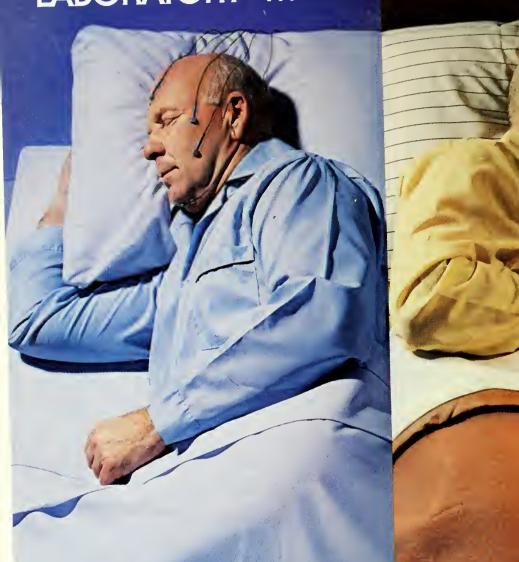
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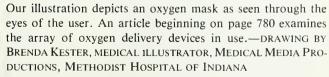
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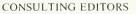
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# ABOUT THE COVER





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# MEDICAL MUSEUM NOTES

CHARLES A. BONSETT, M.D., Indianapolis



HIS PAGE OF NOTES concerns Helene Elise Hermine Knabe, a Germanborn girl (1875) who emigrated to Indiana in 1896 to fulfill her ambition of studying medicine, the opportunity being denied in her homeland because of her sex.

Although she was an excellent student, Helene's upbringing was directed primarily toward developing those attributes essential to becoming a good *hausfrau*. She was steeped in the concept that "you cannot be a master of anything unless you know every detail of the work." Consequently, she became an expert of the needle, not only with conventional sewing, mending and dressmaking, but with all sorts of fancy work to which she applied her native-born talent of freehand drawing.

But it was with nature that the growing girl found her greatest satisfaction. Her home, in a rural setting on the Baltic coast, permitted frequent walks along the beach and into the forest, providing experiences that aroused her curiosity and revealed the wonders of life. It was this background that set the stage for an interest in, and a desire for, a medical education.

In terms of personality, Helene Knabe was an introvert, but she was aggressive and could be as blunt and brusque as the occasion demanded. Her colleagues described her as dedicated, capable and thorough. By some she was considered to be moody and melancholic; by others she was described as warm, sincere and devoted.

It was through circumstance that Indiana came to be her adopted home. An older cousin, Miss August Knabe, had visited Indianapolis in 1895, became involved with teaching the German language in the public school system, and decided to stay. She was joined the following year by Helene, who enrolled in Butler College, then located in Irvington. Helene was admitted to the Medical College of Indiana in 1900.

Internships at that time were available only to male graduates by competitive ex-



Helene Knabe, M.D.

amination. Most of the 1904 graduates (the year Dr. Knabe received her M.D. degree) went directly into practice. Dr. Knabe, who had an interest in pathology, and who had worked as an assistant to Dr. Frank B. Wynn since her sophomore year, was placed in charge of the medical school's laboratories. The following year she was appointed by Dr. John N. Hurty to the Indiana State Låboratory of Hygiene. Her initial work was with diptheria, but during her three years with the state she became the foremost authority on the laboratory diagnosis of rabies and its treatment using the Pasteur method.

In 1908 she resigned her position, being quite outspoken that the long-promised \$1,800 annual salary had never materialized and that the workday could be as long as 16 hours. (A male physician would have been better paid.)

She then opened an office for the practice of medicine in the newly erected Board of Trade Building. Later she moved to the Delaware Flats where she maintained her office in addition to her living quarters. She was practical and frugal.

She was also contentious.

On a wet April day in 1907, she slipped on the prysmatic glass walk in front

of the Traction Terminal Building, fractured an ankle, and promptly brought a \$5,000 lawsuit against the Indianapolis Traction and Terminal Company. Dr. Knabe presented x-ray evidence of her fracture; the x-ray was then regarded as novel, as well as scientific. The jury, just as scientific, visited the scene of the alleged negligence and threw buckets of water on the glass walk so as to make their own determination as to how slippery it would become. Their judgment was not in favor of Dr. Knabe.

In 1909 Dr. Knabe was one of the charter members of the Nu Sigma Phi medical sorority on the occasion of that organization's founding (May 4 at the Dennison Hotel).

By 1911 she had established the foundation of a good medical reputation. She was still struggling to develop a practice for which the competition was very keen, but she was able to augment her income with lectures and by doing medical illustrations. Her future looked bright.

But suddenly her young life was terminated. She was found dead in bed on the morning of Oct. 3, 1911 by her secretary. Dr. Knabe's throat had been cut so deep that the cervical spine was nicked. Her nightgown was up to shoulder level, revealing her nude body. She had not been molested. She had not been robbed. All the doors and windows were locked. No weapon was found.

How and why did it happen?

"Murder," said the coroner.

"Suicide," said the chief of police.

"Nonsense!" said Dr. Hannah Graham, who along with other women physicians throughout the state organized to assure that justice would be done. But it never was. The mystery of Dr. Helene Knabe's death was never solved.

The life and times of Dr. Knabe provide the subject for this year's Indiana Historical Society medical history section meeting, to be conducted Saturday, Nov. 3, at the Indianapolis Airport Hilton, beginning at 9:30 a.m.

# OBESITY.

# THE CONSEQUENCES CAN BE LIFE-SHORTENING.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease...diabetes...hypertension... congestive heart failure...an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight—if, in fact, it is ever achieved.

The Institute for Health Maintenance (IHM) can help.

Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss:

THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long tor

plemented fast with long-term behavioral and nutritional training.

Under the supervision of the IHM medical staff, patients lose weight safely and consistently over a period of weeks and months. They receive their total daily nutritional requirements from a low-calorie egg albumen formulation and a multivitamin tablet...

a supplement they stay with until goal weight is achieved.

The success of the RFO Program has been significant.

Over the past five years, thousands of patients have lost from 25 to over 100 pounds, with the average loss being 63 pounds. More important, 75%\* of these patients have been able to sustain their new low weight levels with the help of our 18-month maintenance program.

Some have called the RFO Program "life-saving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—



one we at IHM can help control.

To learn more about us and how this program can safely benefit some of your patients, please contact one of our medical directors at a clinic near you.

\*Data on file. Institute for Health Maintenance.

The Risk Factor Obesity Program Medically designed. Medically supervised. Medically sound.

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# WHAT'S NEW?

Marion Laboratories is marketing a new rapid diagnostic test for betahemolytic Streptococcus. CULTURETTE Brand 10-Minute Group A Strep ID detects the pathogen on a throat swab and eliminates overnight culturing. It is expected that the ID will become a useful addition to the physician's office and independent and hospital laboratories.

Dosimeter Corporation has prepared a new catalog of Detection and Employee Protection Products. It provides technical information on dosimeters, geiger counters, nonionizing radiation monitors, exhaustless filtered fume hoods, air purifiers, air samplers and Laser Safety Manuals.

**Amko** has a new IUD removal forceps which features a diameter at the jaws of 3 millimeters. The 9-inch alligator forcep has a blunt, tapered tip for easier insertion. It is made of stainless steel. There are two styles of IUD removal hooks also available.

**Key Pharmaceuticals** has FDA approval to market, in the United States, the first 12-hour steroid aerosol for treatment of bronchial asthma. The product was developed and licensed to Key by Syntex. Its trade name is AeroBid. The active component is flunisolide, an anti-inflammatory steroid. It is recommended for twice-a-day dosage and will be available only on prescription.



News of what is new in the medical supply industry is composed of abstracts from news releases by book publishers and manufacturers of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by INDIANA MEDICINE or by the Indiana State Medical Association.

UNILAB, the first and only office diagnostic system to offer routine blood chemistries, plus enzyme immunoassays (EIA) for thyroid function, therapeutic drug assays and B-HCG (quantitative pregnancy tests), has been introduced by Bio-Dynamics, the Indianapolis-based Physician Laboratory Products Division of Boehringer Mannheim Diagnostics. UNILAB's diagnostic potential is designed to be both medically and financially beneficial to the in-office user.

General Electric announces a CT Xenon Cerebral Blood Flow (XeCBF) Imaging System to aid in the diagnosis and evaluation of stroke victims by assisting in determination of the extent of the damage, the timing for surgery, and potential therapeutic benefit. The Xenon CBF option is applicable to the CT 9800 systems.

Medical Frontiers is introducing a home test kit for the identification of gonorrhea in men. The product, called V.D. Alert<sup>TM</sup>, will be sold over-the-counter. It has 95% specificity and provides a presumptive test for the bacterium that causes gonorrhea. By sending the in-home test to Medical Frontiers' CDC Interstate Commerce approved laboratory, V.D. Alert enables men to receive a confidential analysis by calling a toll-free number with a personal identification code.

Geigy has FDA approval to market Brethaire® (terbutaline sulfate), a bronchodilator in the form of an aerosol. It provides fast relief from bronchospasm while avoiding many of the side effects of orally administered bronchodilators. More than 95% of patients treated in the Brethaire clinical studies were not affected by tremor or nervousness.

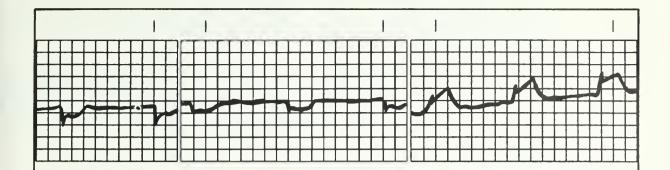
Petrascep Corporation introduces a newly designed cup suitable for bed patients. The 12-ounce capacity cup may be used for drinking in the usual manner from the rim. In addition, the handle of the cup is hollow and extends from the bottom of the cup up to the top and may be used as a drinking straw. The cup, which is named SIP-A-CUP<sup>IM</sup>, is unbreakable, durable and dishwasher safe.

Jung® Medical Products is adding Anti-Embolism Stockings for recumbent patients to its system of elastic graded compression therapy, The VenES® System by FUTURO®. VenES Anti-Embolism Stockings deliver 18 mm Hg compression at the ankle. Features include an expansion panel (gusset) at the top of Thigh Length styles to prevent gartering. Another feature is one-way stretch to minimize slippage.

The Sea Otter Press announces a poster, printed on extra heavy poster stock, which illustrates in full color 40 edible or poisonous mushrooms. Measurements are 37½" × 24¼". The poster was prepared by two eminent botanists. Each illustration is accompanied by information about scientific and common names, seasons of common occurrence, size range of mature specimens, type of habitat and, in the case of the poisonous varieties, the type of toxin each contains and the nature of symptoms induced.

Beckman Instruments is introducing the LMS System 4800 clinical data management system, developed for the laboratory of the 50 to 150 bed hospital. The computer helps the lab organize workflow and provides management tools to enhance the operation of any clinical laboratory. The system interfaces nearly all automated instrumentation so results are transferred to the LMS data bank. Results from manual procedures are entered by technologists at terminals throughout the lab.

Key Pharmaceuticals has acquired, from Knoll AG of West Germany, exclusive marketing rights in the United States to gallopamil, a new potent calcium antagonist. It is anticipated that gallopamil will be on the U.S. market during 1987.



# This misread EKG delayed the patient's admission & treatment—and cost the doctor a malpractice claim.

The doctor who read this EKG diagnosed the patient's nausea as being due to gastroenteritis and sent her home. Six hours after being admitted the next day, the patient expired of an acute MI.

The result: A malpractice claim against the physician.

Recent national evidence, and information from our own claims files, suggests that MIs are frequently misdiagnosed. The EKG above, for example, strongly indicates an acute MI.

We know that insurance coverage alone won't solve the malpractice problem. It will also take reasonable patient expectations. And even greater diligence by physicians.

That's why our medical directors review hundreds of cases each year. Their jobs: To spot problem areas or emerging trends and warn policyholders, through timely publications, medical/legal seminars and other educational presentations.

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DIAGNOSES Unlike typical computer management companies, we never start by presenting a service and trying to shoehorn it into your medical office. Actually, we offer so many services that our first question will be: "What do you really need?"

Then let's sit down and list your billing needs, collection needs, insurance processing needs, management reporting needs, appointment scheduling needs, general business needs, and medical reporting needs.

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English, not computer or management jargon, we'll explain how to
strengthen your financial control. For
example, we can help you design more
effective statements, collection notices, and
routing slips.

Please remember that, while we are always available, we do not make excessive demands on your time. The idea is not to take time, but to save time. Our goal is to free your staff to devote more time to patients and less to paperwork.

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# T. S. DANIELSON, JR., M.D., M.P.H. Acting State Health Commissioner

New information from Office of the Commissioner Indiana State Board of Health 1330 W. Michigan St. Indianapolis, Ind. 46206 317-633-8400

# PUBLIC HEALTH NOTES

Home nursing services have been provided in an organized manner since before the turn of the century. These services began in response to the needs of the urban poor and eventually were extended into rural areas. In the beginning, voluntary agency nurses worked independently in caring for the sick, providing "well baby" care, and giving needed services in the schools. Eventually, government agencies such as county health departments adopted this model for their services.

What is home health care? "Home health care" constitutes those services provided to individuals and families in their place of residence for the purpose of promoting, maintaining or restoring health or minimizing the effects of illness or disabilities.

Home health care services can be a cost-effective alternative to inpatient care and can help prevent premature institutionalization. Home health care services are provided under the direction of a personal physician, who will order both the services that the agency may provide and the frequency of visits. These orders are reviewed and revised at least every 60 days by the physician.

When Medicare went into effect in 1966, the nature of home care services changed. Under Medicare, home health services are defined as part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech, or occupational therapy) which must be available on a visiting basis in the patient's home. The services provided must be directed by a written plan of treatment established and periodically reviewed by a physician.

As a result of Medicare, home care services have changed dramatically from the supportive, non-skilled services which enabled the elderly to remain in their nomes to skilled care following a hospital admission or an episode of acute illness.

Skilled services for eligible persons are reimbursable through Medicare and Medicaid. Many private insurance policies include home health coverage. Medicaid also covers some non-skilled

services provided by a nurse aide or homemaker. Home care services are reimbursed by third-party payees only when they are provided by state-licensed and federally certified home health agencies.

The growth of state-licensed and federally certified home health agencies in Indiana was rather slow throughout the late 1960s and 1970s. By the end of 1979, there were only 47 such agencies and few offered the full range of reimbursable services. No Medicare reimbursable services were available to persons in more than 25 counties. This slow and steady growth rate of about seven new agencies per year continued until July 1982, when we began adding new agencies at the rate of one per month.

This increased to a rate of three per month during the last six months of 1983. This growth has continued in 1984—by the end of July 1984, there were 117 statelicensed and/or federally certified home health agencies in Indiana. Home care services are now available to some extent in all 92 Indiana counties.

This rapid increase in the number of agencies may be due in part to the implementation of Diagnostic Related Groups (DRGs) in hospitals. The anticipation was that Medicare recipients would be discharged sooner (and sicker) and would, therefore, not only be in need of but also eligible to receive skilled home care services. Home health agencies around the state report that, indeed, patients are being discharged from hospitals sooner than in the past and not only are sicker but require highly skilled services which have not been given in the home before.

Many Indiana hospitals have either started or are in the process of starting home care programs. Hospitals have the advantage of being their own referral source. Hospital spokespersons also say that the quality of care could be enhanced by the continuity of care.

Another group of health care providers entering the home care market are nursing homes. The pre-admission screening regulation which went into effect in the spring of 1983 may account for some of this growth because, if the screening team

determines a person is not eligible for nursing home placement, in-home services may be needed.

In a speech delivered at the Indiana Public Health Association's spring conference, Governor Robert Orr spoke of Indiana's health care needs and the problems in meeting these needs and said that "... among our most urgent priorities are home health care, especially for the elderly."

The *Indiana Plan for Health* (1982-1987), developed by the Indiana State Board of Health, lists as a state policy the promotion "of the most cost-effective alternatives that maintain or improve the quality of medical care;" it further states that "cost-effective alternatives to inpatient care should be thoroughly explored."

Some home health agencies offer a full range of services, including physical, occupational, and speech therapies, medical social workers, and nutritional guidance. The primary registered nurse is responsible for coordinating whatever services a person receives to maximize their effectiveness.

In 1983, more than 75% of home health services in Indiana were provided to persons age 65 and over. Many elderly people are in need of nonskilled or supportive services, such as homemakers or home maintenance. The public funding for these types of services is limited. Some persons, however, are able to pay for such services themselves.

Family members are a very important part of home care. Nurses often can teach family members or friends the necessary skills which allow them to provide the care needed so the patient can remain at home. Family members feel more confident and are better able to provide the needed care with the nurse's help, support and supervision.

Home health care services are essential to providing the continuity needed for high quality comprehensive health care. They can greatly extend the time elderly persons may remain in their own home, as well as enhance the quality of life during that time.

# BALANCED CALCIUM CHANNEL BLOCKADE!



# Low incidence of side effects

CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

\*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

#### References

- 1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
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# Reduces angina attack frequency\* 42% to 46% decrease reported in

42% to 46% decrease reported in multicenter study.

# Increases exercise tolerance\*

In Bruce exercise test, control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes (P < .005).

# CARDIZEM

(diltiazem HCl)

THE BALANCED
CALCIUM CHANNEL BLOCKER

#### PROFESSIONAL USE INFORMATION



DESCRIPTION CARDIZEM\* (dilitiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylaminolethyl)-2,3-dihydro-2-(4-methoxyphenyl)-monohydrochloride,(+)-cis- The chemical structure is:

Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral

### **CLINICAL PHARMACOLOGY**

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed

to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.

2. Exertional Angina CARDIZEM has been shown to produce

increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via

reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads. In animal models, ditiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction (depolaring) current in excitation issue, it causes excitation-contraction uncoupling in various myocardial issues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH

interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked oronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction Intravenous ditiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block Dilitazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sixus syndrome, dilitazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not

cycle length jup to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Dilitiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicytic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl dilitazem is also present in the plasma at levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-inearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. dose There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

#### INDICATIONS AND USAGE

Angina Pectoris Due to Coronary Artery Spasm. CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as

treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

2. Chronic Stable Angina (Classic Effort-Associated Angina). CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance. There are no controlled studies of the effectiveness of the concomi-tant use of dilitazem and beta-blockers or of the safety of this

combination in patients with impaired ventricular function or conduction abnormalities

#### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

Cardiac Conduction. CARDIZEM prolongs AV node refrac-1. Cardiac Conduction. CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. Congestive Heart Failure. Although diltiazem has a negative inotropic effect in isolated animal tissue greparations, bemortynamic.

congestive near rating. Although citizen in solated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should

be exercised when using the drug in such patients. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic

Acute Hepatic Injury. In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes (See PRECAUTIONS and ADVERSE REACTIONS.)

#### **PRECAUTIONS**

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In sub-acute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS

Controlled and uncontrolled domestic studies suggest that con-comitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In health volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed

In rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore

use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not

#### **ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies

which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%),

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.5 asthenia (1.2%), AV block (1.1%), in addition, the following ewere reported infrequently (less than 1%) with the order of presetion corresponding to the relative frequency of occurrence

Cardiovascular Flushing, arrhythmia, hypotension, brady dia, palpitations, congestive heart fail

Nervous System Gastrointestinal:

Hypotension

syncope

Paresthesia, nervousness, somnoler tremor, insomnia, hallucinations, and amne Constipation, dyspepsia, diarrhea, vomit mild elevations of alkaline phosphatase, SI

SGPT, and LDH.
Pruritus, petechiae, urticaria, photosensit Dermatologic: Other Polyuria, nocturia

The following additional experiences have been noted A patient with Prinzmetal's angina experiencing episode vasospastic angina developed periods of transient asymptom asystole approximately five hours after receiving a single 60 dose of CARDIZEM.

The following postmarketing events have been reported i quently in patients receiving CARDIZEM: erythema multiforme kopenia; and extreme elevations of alkaline phosphatase, S SCPT LDH and CPK However additional control of the control of

SGPT, LDH, and CPK. However, a definitive cause and effect bet these events and CARDIZEM therapy is yet to be established

#### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been lim Single oral doses of 300 mg of CARDIZEM have been well toler by healthy volunteers. In the event of overdosage or exagger response, appropriate supportive measures should be employ addition to gastric lavage. The following measures may be consid

Administer atropine (0.60 to 1.0 mg) If Bradycardia is no response to vagal blockade, admin isoproterenol cautiously.

Treat as for bradycardia above. Fixed degree AV block should be treated with High-Degree AV

diac pacing Administer inotropic agents (isoproter Cardiac Failure dopamine, or dobutamine) and diuretics. Vasopressors (eg. dopamine or levarte bitartrate).

Actual treatment and dosage should depend on the severity clinical situation and the judgment and experience of the tre

physician.

The oral/LD<sub>50</sub>'s in mice and rats range from 415 to 740 m and from 560 to 810 mg/kg, respectively. The intravenous LD, these species were 60 and 38 mg/kg, respectively. The oral L1 dogs is considered to be in excess of 50 mg/kg, while lethality and 1500 mg/kg. The transitional section of 1500 mg/kg. seen in monkeys at 360 mg/kg. The toxic dose in man is not ki but blood levels in excess of 800 ng/ml have not been assoc with toxicity

#### DOSAGE AND ADMINISTRATION

DOSAGE AND ADMINISTRATION
Exertional Angina Pectoris Due to Atheroscierotic I nary Artery Disease or Angina Pectoris at Rest Due to I nary Artery Spasm. Dosage must be adjusted to each pat needs. Starting with 30 mg four times daily, before meals a bedtime, dosage should be increased gradually (given in d doses three or four times daily) at one- to two-day intervals optimum response is obtained. Although individual patients respond to any dosage level, the average optimum dosage appears to be 180 to 240 mg/day. There are no available data coing dosage requirements in patients with impaired renal or h function. If the drug must be used in such patients, titration sho carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. Sublingual NTG may be taken as required to abort anginal attacks during CARDIZEM therapy.

2. Prophylactic Nitrate Therapy — CARDIZEM may be coadministered with short- and long-acting nitrates, but have been seen extended to the additional contents.

have been no controlled studies to evaluate the antia effectiveness of this combination.

3. Beta-blockers. (See WARNINGS and PRECAUTIONS.)

### **HOW SUPPLIED**

Cardizem 30-mg tablets are supplied in bottles of 100 0088-1771-47) and in Unit Dose Identification Paks of 10C 0088-1771-49). Each green tablet is engraved with MARION side and 1771 engraved on the other CARDIZEM 60-mg tablets are supplied in bottles of 100 (NDC 0088-1772-47) and Dose Identification Paks of 100 (NDC 0088-1772-49). Each tablet is engraved with MARION on one side and 1772 on the Issued 4.

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New information from

Indiana Division

# CANCER CORNER

Interferon Update: Some Good News!

The American Cancer Society announced that it will spend up to \$1.5 million on newly available mouse and rat interferons for laboratory studies.

The animal interferons, made commercially through recombinant DNA technology, will be purchased by the ACS and supplied to researchers. The new studies will enable doctors to optimize the doses and schedules of human interferon used to treat cancer patients, according to the society's senior vice president for research, Dr. Frank J. Rausher, Jr.

"Thus far, the ACS has spent \$6.8 million on interferon research, mainly to determine whether it had any potential as an anti-cancer agent," said Dr. Rauscher.

"We've found that it has, but until now, we've had to postpone the detailed pharmacological studies routinely performed in animals before a drug is tested in patients."

Until the animal interferon became available this year, such studies had been impossible, since interferons are species-specific—that is, human interferon works only in humans, mouse interferon only in mice. Small-scale studies in cancer patients were ethically permissible because earlier research showed that interferon, made every day by the body's white blood cells, would not cause harm and might have an anti-cancer effect.

Since 1978, ACS-sponsored trials have revealed that human interferon is active against kidney cancer, melanoma, breast cancer, Kaposi's sarcoma, and certain types of leukemia and lymphoma, although it has not been effective in every patient. Nor is it known how long its positive effects will last.

Unlike standard anti-cancer drugs, which poison normal cells as well as cancer cells and cause severe side effects, interferon's worst toxicity, for most patients, is an array of flu-like symptoms. These are not dangerous to the patient and subside when treatment is stopped.

"But without the results of animal studies to help us plan and refine interferon treatment, we've been something like a jet pilot who knows how to taxi his airplane around the runway, but hasn't found the controls needed for a take-off," said Dr. Rauscher.

At least three major classes of interferons are made in mammals, including man and mouse. These can now be produced separately, in unlimited quantities and in very pure form, thanks to genetic engineering. The different types of interferons could be used individually to treat cancer patients, or in "cocktails" of various proportions, combined with conventional radiation and chemotherapy.

"The possible treatment strategies are infinite, but it would take years to find out the best one for each type of cancer if we had to rely on what we can learn from using interferon in patients," explained Dr. Rauscher.

"Now that animal interferons can be assessed in laboratory animals, we may start getting preliminary information in a matter of months."

The mouse and rat interferon studies will be performed by independent investigators at institutions to be chosen this summer by an advisory committee to the society.

#### **ACS** Research Report

A new publication, "The American Cancer Society Research Report," is now available. An overview of the society's national research effort, the magazine-style publication focuses primarily on the research grants program—when it began, how it works, what areas are currently under investigation, who our grantees are.

Among the key individuals who should receive the publication are officers of hospitals and medical centers, major contributors, medical and science writers, editors of daily and weekly newspapers, news editors of radio and TV programs, public health officials, corporate leaders, legislators, members of the scientific and

medical community. This publication is a valuable resource for answering inquiries about the society's research program on a year-round basis. Order through the Distribution Office (Code #5601).

### **Education Program for Schools**

To aid in school presentations, a new slide/script program offering an overview of the American Cancer Society's Youth Education program is now available. It gives a brief description of key materials available for grades K-12 such as Early Start to Good Health, Health Network, the new Health Myself Kit, Nature of Cancer Kit, and the films, From One Cell, Take Joy, and Something Very Special. It stresses that these materials are designed to be integrated into the schools' curriculum.

The approximately 10-minute slide presentation is ideal for promoting youth education programs to teachers, principals, and administrators.

### **Professional Education Publication**

Tumors of the head and neck can include a diverse group of cancers affecting the oral cavity, oropharynx, hypopharynx, nasopharynx, nasal cavity, larynx, and paranasal sinuses. The majority of these cancers are squamous cell carcinomas.

A publication called "Cancer of the Head and Neck" contains a series of articles on the staging of head and neck cancers, the role of adjuvant radiation therapy and chemotherapy in the treatment of these cancers, esthesio-neuroblastoma, an unusual epithelial tumor of the nasal olfactory mucosa, a historical vignette on nasopharyngeal cancer, and a landmark article on a special group of lymphoepithelial tumors eponymously designated "Schmincke tumors," for the German pathologist who first described them. Copies may be ordered through the Division Office District Representative. (Code #3346.)

# FUTURE FILE

# **Financial Seminars**

General Alexander Haig will be the keynote speaker at two day-long financial planning seminars entitled "How to Use Switzerland for Privacy and Profit."

The seminars, conducted by Swiss Financial Seminars of Minneapolis, will be conducted Saturday, Oct. 27, at the Knickerbocker Hotel in Chicago and Saturday, Nov. 3, at the L'hotel Sofitel in Minneapolis. Presentations will be given by international bankers, attorneys and other financial advisors. Registration fee, including materials, is \$495.

Contact Swiss Financial Seminars, 5201 Duggan Plaza, Minneapolis 55435—(800) 328-2929, toll-free.

# Indiana University CME

For the Primary Care Physician

Oct. 31—Management of Scoliosis, Holiday Inn, Speedway.

Nov. 2—Management of Orthopedic Problems, Vigo County Public Library, Terre Haute.

Nov. 7—Clinical Endocrinology, Adam's Mark Hotel, Indianapolis.

Nov. 28—OB/GYN Symposium, Indianapolis.

Nov. 29—Clinical Syndromes of Altered Immunity, Reid Memorial Hospital, Richmond.

"Mini-Fellowship in Rheumatology"— 40-hour course, five consecutive days. For details, see the July issue, page 506.

For the Specialist

Nov. 16—Evoked Potentials Seminar, I.U. Medical Center campus.

Nov. 30-Dec. 1—American College of Physicians Regional Meeting.

For additional information, contact the CME Division, Indiana University School of Medicine—(317) 264-8353.

# **Pediatric Brain Insults**

"Brain Insults in Infants and Children: Pathology, Evaluation, Diagnosis and Acute Management" is the title of a CME conference to be held March 7-9 at the Holiday Inn at the Embarcadero, San Diego. AMA/CMA credit is 17 hours.

Contact Office of CME, MO17 UC San Diego School of Medicine, La Jolla, Calif. 92093—(619) 452-3940.

# **Internal Medicine Update**

ISMA members are invited to attend a two-day scientific meeting of the American College of Physicians, which will be held Friday and Saturday, Nov. 30 and Dec. 1. The program will be devoted to updating medical knowledge in the field of internal medicine. The fee for non-members is \$10.

For information and reservations contact Dr. Richard C. Powell, I.U. Medical Center, 1100 W. Michigan St., Indianapolis 46207—(317) 264-8684.

# Clinical Cytopathology

The Johns Hopkins University School of Medicine will offer two postgraduate courses in clinical cytopathology next year. They are solely for pathologists.

For credit, both courses must be taken: March to May 1985, Home Study Course A is provided each registrant for intensive personal study; and from May 6-17 In-Residence Course B will be conducted at the Johns Hopkins Medical Institutions, Baltimore. Upon successful completion, 152 AMA Category I credit hours will be awarded.

For details, write John K. Frost, M.D., 604 Pathology Bldg., The Johns Hopkins Hospital, Baltimore, Md. 21205.

### **Heart Disease**

"New Approaches to the Management of Profound Congestive Heart Failure" will be the subject of the 4th Annual Conference on Heart Disease by the University of Wisconsin Medical School at the Westowner Hotel, Madison, Dec. 7 and 8.

Full information is available from Sarah Aslakson, 465B WARF Bldg., 610 Walnut St., Madison, Wisc. 53705—(608) 263-2856.

The Journal of the American Medical Association publishes a list of CME courses for the United States twice yearly. The January listing features courses offered from March through August; the July listing features courses offered from September through February.

# **Pathology Annual Meeting**

The annual meeting of the U.S.-Canadian Division, International Academy of Pathology, will be held at the Sheraton Centre in Toronto, Canada, March 11-15.

Scientific papers, poster sessions, 13 specialty conferences, and 45 short courses are scheduled. Two special courses will be offered concerning advances in the application of immunocytochemistry to diagnostic surgical pathology, and diagnostic cellular and molecular pathology.

The Maude Abbott Lecture will be delivered March 12 by Dr. Kenneth M. Brinkhous. Timely Topics in Pathology will feature a session on "Pathogenesis and Lesions of Acid Rain" by Dr. Robert Leader.

Further information is available from Dr. Nathan Kaufman, U.S.-Canadian Division, International Academy of Pathology, 1003 Chafee Ave., Augusta, Ga. 30904—(404) 724-2973.

# **Nutrition Meeting**

The American Society for Parenteral and Enteral Nutrition will conduct its 9th Clinical Congress Jan. 21 to 24 at the Fontainbleau Hotel, Miami Beach, Fla.

For details write or phone A.S.P.E.N., 1025 Vermont Avenue, NW, Suite 810, Washington, D.C. 20005—(202) 638-5881.

# Cardiology Course

"New Techniques and Concepts in Cardiology" is the title of a CME course to be conducted Oct. 25-27 by the American College of Cardiology at the Hyatt Regency Hotel, Washington, D.C.

Registration fee is \$280 for members, \$395 for non-members. To register, call the ACC at (301) 897-5400, Ext. 230.

# **Computer Applications**

The eighth annual Symposium on Computer Applications in Medical Care meets Nov. 4-7 at the Washington Hilton Hotel, Washington, D.C.

For details and registration forms contact Bernie Brauner, 810 Vermont Ave. N.W., Washington, D.C. 20420—(202) 389-2059.

# **Kentucky CME Courses**

The following AMA Category 1 courses are offered by the College of Medicine, University of Kentucky:

Oct. 17-20-"New and Changing Clinical Concerns of Internal Medicine,' Hyatt Regency Hotel, Lexington.

Oct. 26-Symposium on Type II Diabetes, Capitol Plaza Hotel, Frankfort,

Nov. 11-16-15th Family Medicine Review: Session 111, Hyatt Regency Hotel, Lexington.

Nov. 30-Dec. 1—"Black Lung Disease: A Model for Management of COPD," Hyatt Regency Hotel, Lexington.

Dec. 21-22—"Treatment of Common Solid Tumors," Hyatt Regency Hotel, Lexington.

Feb. 24-March 1-16th Family Medicine Review: Session 1, Hyatt Regency Hotel, Lexington.

March 22-23-"Advanced Cardiac Life Support," University of Kentucky Medical Center, Lexington.

Contact Joy Greene, 132 College of Medicine Office Bldg., University of Kentucky, Lexington, Ky. 40536—(606) 233-5161.

# **Neurology Conference**

"Neurology for the Non-Neurologist" is the subject of a CME conference Dec. 12 to 14 at the Westin Hotel, Chicago. It is sponsored by the Rush-Presbyterian-St. Luke's Medical Center.

For information, contact the medical center at 600 S. Paulina, Chicago 60612-(312) 942-7095.

# Kokomo Conference

"Practical Management of Psychiatric and Alcoholic Emergencies" will be the subject of a conference Oct. 25 at Howard Community Hospital, Kokomo.

The program, co-sponsored by the hospital and I.U. School of Medicine, will provide a practical approach to the

management of psychiatric and/or alcoholic patients in the office or emergency room.

To register, contact Bev Woodard, Howard Community Hospital, 3500 S. LaFountain St., Kokomo 46902—(317) 453-0702.

# Florida Symposium

"Ear, Nose and Throat Diseases in Children" will be the subject of a fiveday symposium to be presented Dec. 5-9 at The Breakers in Palm Beach by the Depts. of Otolaryngology and Pediatrics of the University of Pittsburgh School of Medicine.

The course offers 17 CME credit hours. Tuition is \$250 for physicians, \$185 for residents.

Contact the Dept. of Otolaryngology, Children's Hospital of Pittsburgh, 125 De Soto St., Pittsburgh, Pa. 15213—(412) 647-5466.

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AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.



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# Snakeroot Extract

Number 3

October, 1984

### A NEWSLETTER OF INDIANA MEDICAL HISTORY

# Society Schedules Session on Women and Medicine for Annual History Conference

The Indiana Medical History Committee of the Indiana istorical Society will sponsor a session on "Women and edicine" during the Annual Indiana History Conference. ne session is scheduled for 9:30 a.m. on Saturday, ovember 3, 1984, at the Airport Hilton and will focus on omen as both patients and physicians. The keynote eaker will be medical historian Judith Walzer Leavitt. In er paper "Gender and the Birthing Room," Dr. Leavitt ill discuss the effects male physicians and midwives had the birthing process from 1750 to 1950. For many ars, midwifery was the domain of women. After the midghteenth century, however, male midwives and phycians entered the birthing room. Dr. Leavitt will amine whether or not men altered the birthing process d will also discuss the role of female physicians in stetrics.

Dr. Leavitt is associate professor of the history of redicine, history of science, and women studies at the liversity of Wisconsin. She is also chairman of the Deertment of the History of Medicine at Wisconsin, and has blished extensively in the history of medicine. Eluded among her long list of publications are Medicine Vtbout Doctors: Home Health Care in American History (977); Sickness and Health in America: Readings in the Istory of Medicine and Public Health (1978); and Vsconsin Medicine: Historical Perspectives (1981). Her nost recent work has been in the field of public health all women and medicine. She has published and lectured elensively on these topics. She has published Women ad Health in America: Historical Readings (1984), The Halthiest City: Milwaukee and the Politics of Health Rorm (1982), and is currently writing Brought to Bed: Immen and Childbirth in America, 1750-1950. She is ab working with Lewis A. Leavitt on a statistical study enparing differing infant feeding practices to infant n rtality rates.

he Medical History Committee's session will also inlude two papers on women and medicine in Indiana.



Judith Walzer Leavitt

Charles A. Bonsett, M.D. will present a paper entitled "The Life and Times of Helen Knabe." Dr. Knabe (1875-1911) was a turn-of-the-century Hoosier physician who was educated in the early proprietary, or private, medical school system. Dr. Bonsett's paper will focus on the difficulties she had obtaining a medical education and establishing a medical practice. In exploring the life of Dr. Knabe, who was murdered in 1911, Dr. Bonsett will also discuss the education and medical practices of other women physicians in Indianapolis. A well known Indianapolis neurologist, Dr. Bonsett has devoted much time and effort to the preservation of medical history in the state. He is founder of the Indiana Historical Society's Medical History Committee and the Indiana Medical History Museum. He has published extensively in the history of medicine in Indiana, and is a Fellow of the American

# W. D. Allison: Manufacturer of Physicians' Furniture

By Katherine Mandusic McDonell

Author's Note: The research for this article was conducted to aid in cataloging an Allison examination table donated to the Indiana Medical History Museum. Dating an object is an essential part of the museum cataloging process. If a local maker's name appears on a medical artifact, there are a variety of sources which the curator can consult for information about the company and its products. Included among these sources are trade catalogs, advertisements in medical journals, incorporation records, city directories, personal papers, and county histories. Occasionally these sources provide a wealth of information about the company, making the curator's job a fascinating one.

The Indiana Medical History Museum recently received a solid oak Allison examination table from William M. Sholty, M.D. of Lafayette, Indiana. The table, which dates to the early 1890s, originally belonged to Dr. Sholty's grandfather, William R. McMahan, M.D. (1843-1903), who practiced medicine in Huntingburg, Indiana. Dr. McMahan was a graduate of Rush Medical College and professor of surgical pathology at Evansville Medical School.

The table is not only of interest because it was owned by an Indiana physician but also because it was manufactured by the W. D. Allison Company, an Indianapolis firm. The company, founded by William David Allison (1854-1928), specialized in "high grade" wood physicians' furniture. Allison was born in Coles County, Illinois and before coming to Indianapolis, worked as a piano and organ salesman. In 1884, he took

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Charles A. Bonsett, M.D., Editor

Ann G. Carmichael, MD., Ph.D., Asst. Editor

Katherine Mandusic McDonell, *Managing Editor*Submit all items for publication in the newsletter and inquiries about membership information to the Managing Editor, c/o

Indiana Historical Society, 315 West Ohio Street, Indianapolis, Indiana 46202.

Snakeroot Extract derives its name from the white snakeroot plant, a plant that is significant in Indiana medical history. For years, a mysterious disease called milk sickness plagued early Hoosiers. There were many theories as to the disease's cause, but the actual cause remained unknown until the 1920s. At that time, the disease was traced to the white snakeroot plant or, rather, to the consumption of milk from cows that had eaten it. The plant contains the poison tremetol.

### PHYSICIANS' FURNITURE

THE ALLISON No. 36 TABLE



The "deluxe" model of the Allison examination table, ca. 1912. Photograph reproduced from W. D. Allison Company, The Allison Line of Physicians' Tables (Indianapolis: W. D. Allison Company, ca. 1912).

over the J. H. Clark & Company, which was founded in 1881 and made a variety of parlor furniture, including the "Elbreg," a patented reclining chair. By 1882, the J. H. Clark & Company had expanded into the physicians' furniture industry. In 1886, Richard B. Roberts purchased Joseph A. Clark's interest in the company and the new company was known as Roberts and Allison until 1891. At that time, William Allison bought out Roberts' interest.

The company claimed that their wood physicians' furniture was not only utilitarian, but was skillfully crafted and had an "artistic design and elegant finish." The company was best known for its "Allison" tables, chairs, and cabinets. The Allison table came with adjustable stirrups and leg supports and could be opened into eleven different positions to facilitate a wide variety of medical examinations and surgical procedures. The "deluxe" model came with cabinets under the table for the storage of instruments and drugs. In the early twentieth century, the price for one of these deluxe tables (including leather upholstery) was \$110. The instrument cabinets manufactured by Allison offered the physician a large number of drawers and shelves for storage. The company also manufactured physicians' office examination chairs which could be adjusted to almost any position. By 1893, the firm claimed that over ten thousand of these chairs were in use by doctors. Allison not only offered physicians a wide variety of styles and models of these chairs, cabinets, and tables, but also manufactured these items to meet individual specifications.

In 1928, William D. Allison died. The company remained family owned and operated, however, and continued to prosper and thrive. In March, 1929, the firm decided to expand its operations and purchased the Old Stutz Fire Engine Company on Birdsal Parkway, leaving its Alabama Street location where it had been located for

(Continued on Page 3)

# **Society Schedules Session**

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Academy of Neurology and a member of the Indiana Academy.

Katherine Mandusic McDonell will present a paper entitled "The Obstetrical Cases of Dr. William A. Lindsay." Lindsay (1796-1876) was a Richmond surgeon who kept a detailed record of his surgical cases. His obstetrical cases exemplify the experiences midwestern practitioners faced when they were confronted with difficult deliveries. Ms. McDonell is the medical research historian at the Indiana Historical Society and curator of the Indiana Medical History Museum. She has authored several articles on the history of medicine in Indiana and is editing the journals of Dr. William A. Lindsay for publication by the Indiana Historical Society.

The session will be chaired by Ann G. Carmichael, M.D., Ph.D. Dr. Carmichael is medical historian at the Indiana Historical Society and assistant professor in the Departments of History and the History and Philosophy of Science at Indiana University.

Those interested in attending the Medical History Committee's session, "Women and Medicine," must register for the History Conference. The registration fee is \$5.00. For more information about the conference and luncheon reservations, contact the Indiana Historical Society, 315 West Ohio Street, Indianapolis, Indiana 46202 (317/232-1882).

# W. D. Allison

(Continued from Page 2)

thirty years. From 1930 until 1951, Allison's son-in-law, Eli Lilly, served on the board of directors (Eli Lilly had married Ruth Allison). In 1947, the company began producing some metal furniture, although during most of its history, the firm manufactured exclusively wood furniture. Finally, in 1961, Allison was sold to Shampaigne Industries in St. Louis which continues to make physicians' furniture.

Throughout its existence in Indianapolis, the W. D. Allison Company was not alone in the manufacture of physicians' furniture in the city. In 1893, for example, the Drake & Wood Company and the Miner & Elbreg Company also produced physicians' furniture. In 1896, Joseph H. Clark and Richard B. Roberts, former partners of William D. Allison, formed a company and joined the probably already overcrowded physicians' furniture market in Indianapolis. All of Allison's competitors manufactured a "unique" physicians' examination chair. Probably because of the number of firms manufacturing and selling examination chairs similar to theirs, the



William David Allison (1854-1928). Photograph courtesy Mrs. John L. Davis, Indianapolis.

Allison Company in 1893 claimed: "Counterfeiters [of examination chairs] are abroad in the land, but as the mechanism of our Chair is patented, they can only copy the outward design, and attempt to palm off a cheap article on the unsuspecting public. *'Be not Deceived.'*"

Of all the physicians' furniture manufacturers in Indianapolis, only Miner's company (which was founded by William D. Allison's brother-in-law, Benjamin D. Miner) survived to compete with Allison. The Miner & Elbreg Company changed its name to the Perfection Chair Company in 1902 or 1903 and in 1917, it became the American Metal Furniture Company. While Allison specialized in wood physicians' furniture, Miner's company manufactured only metal physicians' furniture. The company continued in existence until 1967, when Miner's grandson, Joseph A. Miner, Jr., of Indianapolis sold the business to the Overmeyer Company in Winchester, Indiana. The company was, in turn, sold to the Midmark Corporation in Versailles, Ohio. The sale of both the W. D. Allison Company and the American Metal Furniture Company ended Indianapolis' long connection with the manufacture of physicians' furniture.1

<sup>1</sup> Specific works consulted in this article were W. D. Allison Company, The Allison Line of Physicians' Tables (Indianapolis: W. D. Allison Company, ca. 1912); William H. Armstrong, Catalogue of Surgical Instruments, Deformity Apparatus, Aseptic Furniture, and Hospital Supplies, 4th ed. (Indianapolis, 1901); Open House: W. D. Allison Company, November 7, 1947 (Indianapolis, 1947); W. D. Allison Company, Annual Domestic Incorporation Reports, State of Indiana, 1928-1960, Archives, Indiana State Library, Indianapolis, Perfection Chair Company, Ibid., 1907-1951; The Indianapolis Star, January 29, 1925; Personal papers and letters of William David Allison, private collection of Mrs. John L. Davis, Indianapolis; Indiana Medical Journal, Vol. XII (August, 1893); The Medical and Surgical Monitor, Vol. V (April 15, 1902); R. L. Polk and Company, Indianapolis City Directory, 1893-1961; Indianapolis To-Day (Indianapolis: Consolidated Illustrated Company, 1896); Jacob Piatt Dunn, Greater Indianapolis: The History, the Industries, the Institutions, and the People of a City of Homes (Chicago: Lewis Publishing Company, 1910); and George R. Wilson, History of Dubois County from Its Primitive Days to 1910 (George R. Wilson, 1910).

# **Museum Hires Firm To Perform Survey**

The Indiana Medical History Museum has hired the firm of Richardson, Munson, and Weir to perform a mechanical systems/architectural survey of the historic Old Pathology Building (which houses the museum). This company renovated and restored St. John's Church in Indianapolis and converted the Old Cathedral High School to the Catholic Center of Indianapolis.

Prior to renovation of the Old Pathology Building, it will be necessary to introduce climate control into this building to stabilize the environment. High heat and humidity are destructive to a building's interior, as well as to the artifacts within that building. The firm of Richardson, Munson, and Weir will recommend heating, air conditioning, and humidity control systems for the Old Pathology Building to achieve an optimum indoor climate (68°F and 55% relative humidity). The company will also determine how such systems can be installed in this registered national landmark without destroying its integrity. Furthermore, the firm will assess the building's present electrical, plumbing, alarm, and sprinkler systems and

NOTICE: The Indiana Medical History Society, Inc. will meet on Sunday, October 21, 1984, at 2 p.m. at the Radisson Plaza Hotel in Meeting Room One. The meeting will be held in conjunction with the Indiana State Medical Association's Annual Convention.

Indiana Historical Society
Indiana Medical History Committee
315 West Ohio Street
Indianapolis, IN 46202



Photograph by John May An exterior view of the Old Pathology Building

suggest how these systems can be upgraded to insure the safety of the building. The firm will then determine the extent and costs of refurbishing both the interior and exterior of the building. This study, which should be completed by late fall, will be used by the fund-raising committee to determine the extent and scope of a capital campaign to raise the money necessary to install new mechanical systems and renovate the Old Pathology Building.

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To obtain Category 1 credit for this month's article, complete the quiz on page 823.



# **Child Safety Seats: Proper Use and Selection**

### Abstract

Automobile accidents are a leading cause of death for young children in In-

diana. In 1983, 22 children under 5 were killed and 1,469 were injured in automobile accidents on Indiana highways. Up to 93% of automobile passenger deaths occurring in preschool children could be prevented by proper use of car seats and seat belts. The Indiana child

Associate Professor of Pediatrics and Director, Automotive Safety for Children Program, Riley Hospital.

<sup>2</sup>Research Associate, Automotive Safety for Children Program, Riley Hospital.

<sup>3</sup>Education Specialist, Automotive Safety for Children Program, Riley Hospital.

Correspondence: Marilyn J. Bull, M.D., Riley Children's Hospital, Rm. P-121, Indiana University School of Medicine, 702 Barnhill Drive, Indianapolis, Ind 46223.

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MARILYN J. BULL, M.D.<sup>1</sup> KAREN BRUNER STROUP, M.A.<sup>2</sup> CARIJANE ALLEY, B.A.<sup>3</sup> Indianapolis

passenger protection law was enacted on Jan. 1, 1984 and physicians need to be aware of the specific information necessary for parents to safely restrain their children in the car.

Infant-only seats are designed for children from birth to approximately 20 pounds. An infant-only seat is always placed rear-facing and in a semi-reclined position. Most toddler seats are conver-

tible, which means that they can accommodate a child from birth to approximately 40 pounds. After a child is too large to fit in the rear-facing position, a convertible seat may be placed forwardfacing. In the forward-facing position, seat belts are attached at the back of the seat, usually through an L-shaped frame or slots in the shell of the seat. Booster seats are designed for children from 30 to approximately 60 pounds. Most booster seats require the use of a chest harness and tether strap when the child is riding in the back seat of a car. A few booster seats, however, may be used with only a lap belt.

When selecting a safety seat, parents should consider the age, size, and weight of the child. The safety seat also should be appropriate for the size of the car and the type of seat belts in use. Also, parents should select a seat that is convenient to use on a daily basis.

NDIANA LAW now requires that children under the age of 3 ride in a federally approved and correctly used safety seat. Children aged 3 and 4 may ride either in a safety seat or seat belt. It is anticipated that the law will encourage an increased use of safety seats and also will generate many questions on how to properly use and select a safety seat for a child.

The purpose of this article is to provide information for Indiana physicians on (1) the basic types of safety seats for children from birth to 60 pounds, and (2) the factors that should be considered when obtaining a safety seat.

### Infant-Only Seats

Infant-only seats are appropriate for a baby from birth to approximately 20 pounds and should face the rear of the automobile in both the front and back seats (Figure 1). The seat back that the infant faces should be padded to its full height. The internal harness retains the infant in the seat during side and rearend impact and during rebound from front collision. The infant should ride facing the rear of the car as long as possible since on front impact the entire head, neck, and back of the baby are pressed into the impact-absorbing shell of the seat.

Infant-only seats do not provide adequate protection in the forward-facing position. For example, in laboratory tests of the Century Infant Love Seat misused in the forward-facing position,<sup>2</sup> the dummy slid forward in the seat, its neck was hyperextended by the lap belt and its crotch contacted the lower anchor point of the shoulder straps close to where an infant's feet normally would be positioned. For protection in all car safety seats, the child must be secured into the car seat with the internal harness straps and/or shield and the seat must be fastened into the car with the car lap belt.

Blanket rolls may be used to pad the sides and crotch strap area of the infant seat to center the child and prevent him from sliding to the side or forward in the seat (Figure 2). Infants should wear clothing that separates their legs so that the harness strap can fit between the legs.

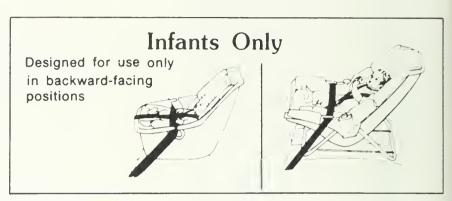


FIGURE 1: Examples of infant-only safety seats.

An infant should be covered with blankets only after being firmly secured in the safety seat with the internal harness.

If a young child is unaccustomed to travel in any car seat, a parent may want to plan a series of short trips before expecting the child to ride comfortably for long periods of time. Special travel bags containing soft toys, games, and snack foods may be given to the child only when they ride properly in their car seat. The child should be praised frequently for remaining still in the car seat. Parents

FIGURE 2: Blanket rolls support head and trunk of premature baby in infantonly safety seat.

should also practice seat belt use if they expect their children to continue the habit willingly.

Many parents remove the child from the safety seat while traveling; instead, they should be encouraged to plan trips with frequent stops for feeding and other child care needs. Parents should not hold an infant or young child in their arms or lap. In a crash or even sudden stop, a small child could be crushed against a windshield or dashboard by the parent's body. Many parents incorrectly assume that if they are restrained by a seat belt, they would be able to securely hold their child should an impact situation occur. However, the tremendous crash forces incurred in even low-speed impact would rip a child from the parent's arms. Placing a seat belt around both a parent and a child held in the lap only increases the chances that a child would sustain serious or fatal injury from both the weight of the parent against the child and pressure from the seat belt.

Parents commonly mistake infant carriers or "pumpkin seats" for car seats. To avoid purchasing an inappropriate or unsafe product, parents should check for a label on the safety seat stating that the seat has been dynamically tested and/or meets current requirements of federal motor vehicle standard 213 (FMVSS No. 213)<sup>3</sup> for providing proper protection in crash conditions. The label on the car seat also should indicate a date of manufacture after Jan. 1, 1981. Safety seats manufactured prior to Jan. 1, 1981 may not meet all of the safety requirements

set by FMVSS No. 213. A few seats manufactured before 1981 were dynamically tested and still meet the current FMVSS No. 213. Parents should check the date of manufacture on the back of the seat before purchasing a used safety seat. Many older seats lack an adequate internal harness system and will collapse on impact (*Figure 3*). Parents should contact manufacturers if there are questions concerning a safety seat's capabilities for protecting a child.

Most infant-only car safety seats have several positions that can be used for feeding and comfort outside of the motor vehicle. Some of these positions are not approved, however, for in-car use and care must be taken to use only the correct positions to insure optimal protection. Babies may be placed correctly in infant-only seats before entering the car and because this type of seat is so lightweight, infants can be transported to and from the car with ease.



FIGURE 3: This car seat, which collapses at the seat back and lacks a five-point harness or shield, does not meet current federal safety standards.

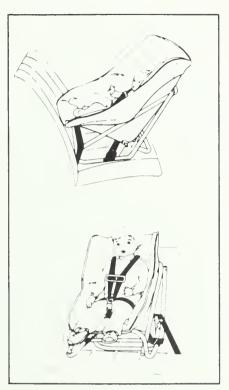


FIGURE 4: A convertible seat; the top diagram shows the infant position, while the bottom diagram shows the toddler position.

### **Toddler Seats**

Toddler seats face forward in both the back and front seats of the car. Seat belts are attached at the back of the seat, usually through an L-shaped frame or slots in the shell of the seat. Toddler seats retain the child in the seat at five points: over both shoulders, across both sides of the pelvis, and between the legs (Figure 4).

Some toddler seats have a soft padded shield that cushions the child's pelvic area. A shield is an integral part of the seat's harness system and must be used at all times (Figure 5). Safety seats with large shields should not be used for children who wear eyeglasses. An armrest on a toddler seat is positioned much farther from the child's body than a shield. This padded tray does not protect the child, but simply allows him a resting point for his arms. Owners of small cars should make certain that the shield or

armrest, when released, can spring all the way up to allow the child to easily enter the seat.

The Century Child Love Seat and the pre-1983 Strolee Wee Care require the use of a tether strap that must be installed directly behind the seat in a solid metal structural part of the car at an angle of 45 degrees or less. When a tether strap is specifically required, it must be installed as illustrated in *Figure 6*.

Since most toddler seats convert from an infant to a toddler seat, the seat frame may be reclined in various positions. In the forward-facing mode, the seat back should be in the most upright position.

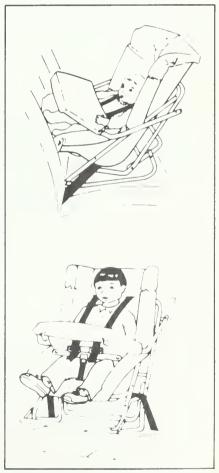


FIGURE 5: A convertible seat with a shield; the top diagram shows the infant position, while the bottom diagram shows the toddler position.

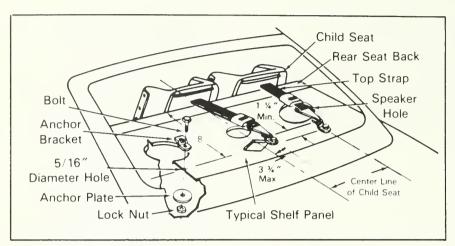


FIGURE 6: Proper tether strap installation for the back ledge of an automobile.

In the rear-facing position for infants, the seat should be adjusted to the most reclined position. Convertible seats are appropriate for a child from birth to approximately 40 pounds.

### **Booster Seats**

Booster seats are designed for older children from 30 to approximately 60 pounds. The top half of a child's head must not extend beyond the height of the car's seat back when he is sitting in a booster seat. Most booster seats require that a chest harness and tether strap be used when a child is riding in the rear seat of a car. In the front seat, a lap-shoulder system provides proper protection (*Figure 7*). A second type of booster seat requires that only a seat belt be placed over a shield that covers the child's lower chest and pelvic area.

Many parents fail to use the chest harness/tether strap that is required for most booster seats when the child is in the rear seat of an automobile. Laboratory investigations have shown that head injury is most likely to result when a booster seat is used with a lap belt only.<sup>2</sup> Unfortunately, many people associate booster seats with "booster chairs" commonly found in restaurants. A booster seat in a car provides a child an opportunity to see outside and protects an older child who has outgrown his toddler seat but is still not large enough for a seat belt only.

Most manufacturers advise that when a child weighs approximately 30 pounds, they may be placed in a booster seat. In a booster seat, the child is restrained primarily in the pelvic area but in a full-size car seat, crash forces are distributed over the child's pelvis and trunk. While the protection afforded by a toddler seat is greater than a booster seat, the duration of use for the toddler seat is less than for a booster should parents decide to obtain a car seat when their child approaches the 30-pound range.

### Selecting a Safety Seat

Parents should consider which type of seat is appropriate for the age and size of their child and how convenient the seat is to use on a everyday basis. For instance, if a safety seat requires the use of internal harness straps in addition to a shield, the parent should realize that all essential parts must be used every time the child is placed into the seat. Also, the size of the car and the type of seat belts may affect which safety seat model can be used. Convertible seats should be placed on the seat in both the fully reclined infant position and the upright toddler position to determine if the seat of the car is of appropriate depth for the car seat model selected.

When the lap-shoulder belt is attached in the front seat of a car, parents need to check whether or not the metal latch plate on the car seat belt webbing is secured or free-moving. If the latch plate can slide freely, parents need to purchase a locking clip. A locking clip is attached close to the latch plate and tightens the lap-shoulder webbing so that the safety seat is held more securely (Figure 8).

It is essential that persons transporting young children understand how to use a safety seat correctly. Manufacturers pro-

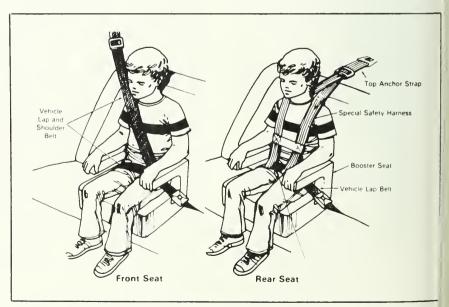


FIGURE 7: Many booster seats require only the lap-shoulder belt system in the front seat of a car; in the rear seat, a chest harness and tether strap must be used.

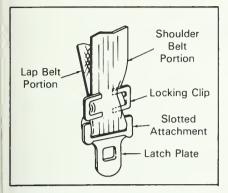


FIGURE 8: Correct placement of a locking clip.

vide detailed instructions on correct safety seat installation, but many parents become confused and frustrated when they read information that appears too technical. Also, many parents may not take the time to read the instructions, thinking that it is impossible to use a safety seat improperly. Unfortunately, misuse of safety seats does occur.<sup>4</sup>

Medical and health and safety professionals must continue to provide needed education and information to parents to help increase proper selection and correct use of safety seats in Indiana. One source for information on safety seat selection and use is the Automotive Safety for Children Program at James Whitcomb Riley Hospital for Children. Questions on the child passenger restraint legislation and safety seat selection and use can be directed to the program by telephone at 317-264-2977 or correspondence at 702 Barnhill Drive, Room P-121, Indianapolis, Ind. 46223. Brochures appropriate for patient distribution can be obtained at no charge by calling 317-232-1300 or

writing the Indiana Department of Highways, Division of Traffic Safety, Room 801, State Office Building, 100 N. Senate Ave., Indianapolis, Ind. 46204.

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# Supplemental Oxygen Therapy for Adults

DAVID J. POWNER, M.D. Indianapolis

HYSICIANS ORDERING supplemental oxygen for patient use may select from a wide variety of oxygen delivery devices. Ideally, the system chosen should provide: 1) a fractional concentration of inspired oxygen (FIO<sub>2</sub>) which is 2) humidified and 3) delivered at an adequate flow rate so that the final tracheal FIO<sub>2</sub> will provide the intended increase in blood oxygen. The tracheal FIO<sub>2</sub> differs from the system FIO<sub>2</sub> when the oxygen delivered from the device is diluted by room air entrained into the airway through or around the therapy system.

The amount of air entrained is determined by the difference between the patient's inspiratory flow rate and the flow rate of gas supplied by the oxygen delivery system. Therefore, if a hyperpneic patient with a high spontaneous inspiratory flow is treated with a device incapable of meeting that demand, the respiratory gas mixture delivered to the patient will be diluted by room air ( $FIO_2 = .21$ ) and the resultant tracheal  $FIO_2$  reduced accordingly.

The occurrence of air entrainment can be documented at the bedside when a nebulizer is used by observing the mist delivered to the patient's face. If the mist is totally inhaled with each inspiration, the flow capability of the device is being exceeded by the patient's demand and air entrainment is occurring. Under such circumstances the tracheal FIO<sub>2</sub> will be

unknown unless measured directly by sampling through a transcricoid membrane puncture.<sup>1</sup>

The relative humidity of oxygen supplied from an oxygen cylinder or piped in-wall source is less than 1%, that is, it carries less than 1% of the water vapor that it would if it were 100% saturated at the ambient temperature and atmospheric pressure. Although gas humidification to reduce water loss from the mucous membrane may be of questionable value in the well-hydrated, non-intubated patient, it is essential for patients whose physiologic humidification system has been by-passed through tracheal intubation.

Various humidifiers or nebulizers supply water vapor to the inspired oxygen with differing efficiency and thus different levels of humidification are possible depending upon the device chosen. <sup>2,3</sup> Simple "bubbler" humidifiers and "blow-by humidifiers" are the least efficient whereas nebulizers when heated may fully saturate (relative humidity-100%) the inspired gas.

Therefore, the patient's requirements for oxygen, gas humidification, or flow from the device and his/her willingness or ability to cooperate with therapy should largely determine which device is ordered.

Nasal Cannula—The nasal cannula is a simple and comfortable device that allows the patient freedom for eating, drinking, and conversation during oxygen therapy. At system flow rates of 4 to 8 L/min. and normal inspiratory flows, the cannula provides a tracheal FIO<sub>2</sub> of 0.35 to 0.45. To prevent drying of the nasal mucosa at low flow rates, a small amount of humidification can be provided by a "bubbler" type humidifier, but at high flow rates mucosal drying and sinus pain may occur. This device is useful when small amounts of supplemental oxygen

are acceptable in a well-hydrated patient. It does not provide precise oxygen concentrations or high flows and should not be relied upon in a hyperpneic patient or a patient with obstruction of the nose or nasopharynx.

Venturi Mask (Fig. 1)—The venturi mask (oro-nasal or tracheostomy) delivers relatively fixed  $O_2$  concentrations (24, 28, 31, 40%) at an increased flow (up to 84 L/min.) because of precise air entrainment within the system. The tracheal FIO<sub>2</sub> therefore is less likely to be altered

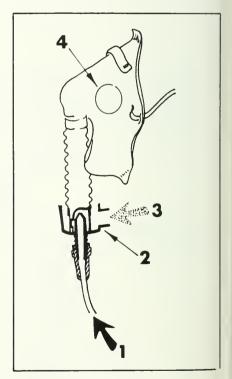


FIGURE 1: VENTURI MASK. (1) Oxygen supply line from oxygen source; (2, 3) High humidity collar (2) and port for large bore tubing (3) for additional humidity; (4) Standard aerosol type mask with two large holes provided for exhalation (air entrainment will occur if system flow is inadequate).

The author is Medical Director, Adult Intensive Care Units, Methodist Hospital of Indiana, 1604 N. Capitol Ave., Indianapolis, Ind. 46202.

through additional air dilution by the patient than with the nasal cannula. Some humidity is added to the source oxygen by the room air entrained and additional humidification can be provided by a bubble-type humidifier or a nebulizer and high humidity "collar." The venturi mask is the system of choice when high-flow, controlled-oxygen therapy is indicated.

Simple Mask (Fig. 2)—The simple oronasal mask is often used to meet shortterm transport or emergency needs. Oxygen is supplied through small bore tubing connected to a dry gas source or bubble-type humidifier. Exhaled air is vented through ports on both sides of the mask and around the mask, but depending on the patient's inspiratory flow and adjusted oxygen flow air entrainment may occur through these same ports. At an oxygen flow of 8-12 L/min. a tracheal FIO<sub>2</sub> of 0.35 to 0.45 can be expected if the patient's inspiratory flow rate is not excessive. This too must be considered a low efficiency device to be used only when an imprecise, low flow, poor humidity system is acceptable.

Partial Rebreathing Mask (Fig. 3)—The partial rebreathing mask, consisting of a face mask, reservoir bag and

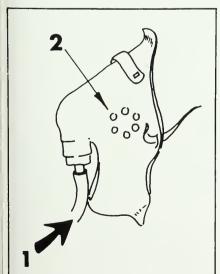


FIGURE 2: SIMPLE FACE MASK. (1) Oxygen supply tubing; (2) Side holes for exhalation and air entrainment.

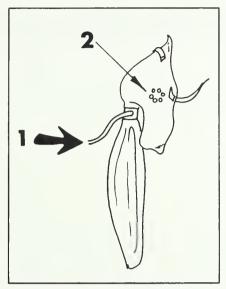


FIGURE 3: PARTIAL REBREATHING MASK. (1) Oxygen supply tubing; (2) Side holes for exhalation and air entrainment.

small bore oxygen delivery tubing can provide an FIO<sub>2</sub> of 0.85 to 0.95. To minimize air entrainment and rebreathing, oxygen flow to the reservoir bag is adjusted to a level at which the bag is continuously distended, thereby assuring that the gas supply matches or exceeds the patient's demand. Some humidification can be supplied by using a bubble-type humidifier. This system permits rapid availability to high concentrations of inspired oxygen and is useful in emergency settings for short-term use.

Non-Rebreathing Mask (Fig. 4)—The non-rebreathing mask is similar to the previous device but incorporates a tightly fitted mask and three one-way valves. The valve located between the mask and the reservoir bag directs oxygen flow from the bag to the patient and prevents entry of exhaled air into the reservoir bag. The second valve vents exhaled gas to the atmosphere and prevents air entrainment. The third valve is a safety inlet valve permitting the patient to draw in room air if oxygen flow is inadequate. To obtain a high FIO<sub>2</sub> (0.85 to 0.95) the oxygen flow is adjusted to distend the reservoir bag. Although this system can potentially

deliver 100% oxygen, this level cannot consistently be achieved because of air leaks around the mask and air entrainment through the safety inlet valve. Some humidification of the inspired oxygen is usually accomplished with a bubble-type humidifier.

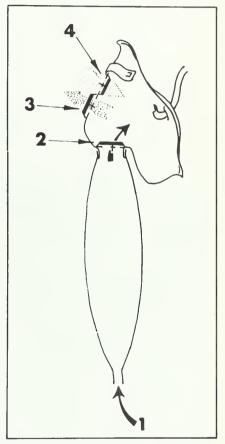


FIGURE 4: NON-REBREATHING MASK. (1) Oxygen supply tubing; (2) Inspiratory valve; (3) Expiratory valve; (4) Safety inlet valve.

Aerosol Mask and Nebulizer (Fig. 5)—This system allows complete humidification of the source gas when a heated humidifier/nebulizer is used.<sup>2,3</sup> Various nebulizers permit a selection of oxygen concentrations at moderate flow (up to approximately 50 L/min), but air entrainment can easily occur through the side holes of the mask. The tracheal FIO<sub>2</sub> is therefore variable. As the device

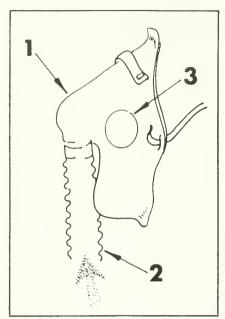


FIGURE 5: AEROSOL MASK. (1) Aerosol mask; (2) Large bore tubing from nebulizer; (3) Two large holes provided for exhalation and air entrainment.

commonly used for long-term oxygen supplementation, this system offers a reasonable compromise of humidity, flow, and FIO<sub>2</sub> for a patient without special needs. Higher flow for the hyperpneic patient is possible by adding a second nebulizer in parallel.

CPAP by Facemask (Fig. 6)—If arterial oxygenation remains unsatisfactory with the above systems and the patient is alert, cooperative, and able to protect his airway, a continuous positive airway pressure (CPAP) system with a tightly fitted face mask may be attempted. This breathing circuit provides expiratory positive airway pressure (EPAP) during spontaneous ventilation similar to that used during mechanical ventilation as positive end-expiratory pressure (PEEP). The beneficial effect of EPAP on arterial oxygenation is through improvement in functional residual capa-

city and a decrease in pulmonary shunting so that the FIO<sub>2</sub> can be reduced to below toxic levels. In addition, a high inspiratory flow provides positive airway pressure during inspiration (IPAP) and reduces the patient's work of breathing. Both pressures require a tight seal over the face by the mask which is secured by

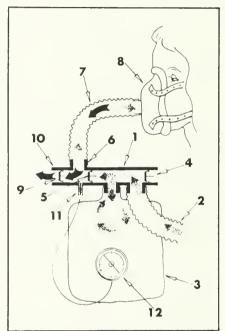


FIGURE 6: CONTINUOUS POSITIVE **PRESSURE AIRWAY** (CPAP) ASSEMBLY. (1) CPAP assembly; (2) Large bore tubing from nebulizer and oxygen source; (3) Reservoir bag; (4) Safety inlet valve; (5) Inspiratory valve; (6) Patient port; (7) Flex tube; (8) Face mask with strap; (9) Expiratory valve; (10) Expiratory port (for PEEP device); (11) Pressure and FIO, monitoring port; (12) Pressure gauge. Gas moves from the wall nebulizer(s) to the reservoir and to the patient. Exhaled gas is diverted by the one-way valve assembly to the PEEP device which provides expiratory pressure.

a strap around the patient's head. A nasogastric tube is recommended to prevent gastric air insufflation and the attendant risk of emesis with aspiration. This system may interfere with bronchial hygiene, coughing, suctioning, and eating and ischemic facial skin changes may occur due to the mask pressure. Those changes in the cardiovascular system which may be encountered with PEEP may also occur with a CPAP system. Complete humidification will be obtained if heated nebulizers are used. This system importantly provides maximal oxygen supplement without intubation and is an excellent system for selected patients.

If the above techniques are ineffective in reversing hypoxemia or cannot be utilized because of poor airway protection, decreased level of consciousness, etc., only then will tracheal intubation be necessary. Thus, as with all medical therapy, the provision of supplemental oxygen should be designed to accomplish a predeterminted goal and titrated against the usual measure of success, the arterial blood gas. The ability of the physician to fulfill this intent will be enhanced by selecting the proper respiratory therapy system.

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# **Peritoneal Dialysis**

THEODORE F. HEGEMAN, M.D. Indianapolis

A Recent
Modification of
Peritoneal Dialysis
Has Led to a
Resurgence in
Its Utilization
in Chronic
Renal Failure . . .

by long-term dialysis in the United States today. In addition, acute renal failure is often prolonged enough that dialytic support is required. Hemodialysis remains the more frequently used modality in both the chronic and acute settings. However, a recent modification of peritoneal dialysis has led to a resurgence in its utilization in chronic renal failure, and peritoneal dialysis does offer certain advantages in acute situations, as well.

Starling published data in 1896 concerning the permeability of the peritoneum. Other early investigators recognized the potential for the removal of endogenous wastes by the peritoneal route. However, safe, especially repetitive, access to the peritoneal cavity was the limiting factor, and it was not until the mid-1960s that a practical method for such access was perfected.

Although the peritoneal surface is quite large, the number of capillaries it contains is small, and these are separated from the peritoneal cavity by relatively large distances (the interstitial space). Fluid (dialysate) once infused into the cavity is stagnant until drained, resulting in resistance to transport of various substances from the blood.

Solute or waste removal is not only dependent upon the resistance to its movement across the separating membranes and spaces, but also the flow rates of the blood through the capillaries of the peritoneum and the dialysate into and out of the cavity. The former is relatively fixed by cardiac output.

Dialysate flow is limited by patient tolerance, as most will not hold more than two liters of fluid at any one time. Dialysate can be infused by a pump rapidly. However, drainage must be by gravity or intra-abdominal contents will be entrapped in the catheter. Flow rates of dialysate above four liters per hour are not possible.

In contrast, hemodialysis utilizes ultrathin artificial membranes with only a few microns separating the blood and dialysate and with high blood and dialysate flow rates (250 and 500 ml/minute, respectively). Fluid removal, necessary in the oliguric patient, is a result of osmosis in peritoneal dialysis and ultrafiltration in hemodialysis. The latter involves increasing the pressure gradient across the artificial membrane in the direction of movement of fluid from the blood with transmembrane pressures as high as 500 mm Hg. The force of osmosis is only at the level of a few mm Hg. Thus, hemodialysis is far more efficient for both fluid and waste removal.

Clinical application of dialysis should be considered in the settings of acute and chronic renal failure separately. The indications for dialytic intervention in acute renal failure are listed in *Table 1*. Fluid removal with peritoneal dialysis, as mentioned, is small per unit of time. However, by frequent exchanges of dialysate over several days, large amounts (often 10-15 kgs.) can be removed from the fluid overloaded patient. The relatively small volumes that cross from the blood into the peritoneum each hour place little stress upon the often unstable cardiovascular system of acutely ill patients.

Excessively catabolic patients require large quantities of waste removal daily or progressive azotemia results. The low efficiency of diffusive transport across the peritoneal membrane may limit the ability of this dialytic method to "keep up" with catabolism. Not infrequently, a patient must be converted to hemodialysis because of increasingly worsening values reflecting the outstripping of peritoneal dialysis by catabolism.

Potassium and hydrogen ion homeostasis can usually be well maintained with peritoneal dialysis. Commercial dialysate is only available without potassium. Addition of this cation can be tailored to the individual patient's needs—overall potas-

The author, a nephrologist in private practice, is medical director of the Dialysis Institute of Indiana.

Correspondence: Nephrology and Internal Medicine, Inc., 1633 N. Capitol Ave., Suite 722, Indianapolis, Ind. 46202.

sium balance can be negative or positive. Dialysate also does not contain bicarbonate. Calcium, a necessary component of dialysate, will precipitate from solution if the pH of the solution is elevated, as would be the case if it contained bicarbonate. Instead, acetate, or more commonly lactate, is added in manufacture.

These base precursors, when absorbed into the blood, are metabolized via the tricarboxylic acid cycle in the liver with production of bicarbonate. Generally, net positive bicarbonate balance occurs, often to the point of frank metabolic alkalosis, after a two or three day dialysis.

Finally, the simplicity of peritoneal dialysis allows use in a multitude of settings. Access placement is a bedside procedure, and only limited by recent surgery, previous processes resulting in effective loss of the peritoneal space, communication from the peritoneum into other body cavities, or large hernias.

Chronic renal failure leads to the same perturbations as those seen with acute renal failure. However, the long period of gradual decline in function and concomitant slow elevation of wastes normally excreted by the kidneys is coupled with preservation of homeostatic control of fluid and electrolytes until late in the course of most progressive renal diseases.

In addition, the patient's needs are more than just physiologic balance. Returning to meaningful social interaction with a time-consuming, chronic procedure must be considered on an individual basis to distract from the patient's previous level of socialization as little as possible.

The indications for chronic assumption of dialysis listed in *Table 2* are really just rearranged from those in the acute setting. Rarely do hyperkalemia or acidosis become unmanageable medically. Even with glomerular filtration rates (GFR) of 5-10% of normal, fluid can usually be handled with loop diuretics. We are left, then, with symptomatic uremia and the level of azotemia as the primary factors to be followed in patients with progressive renal failure.

Standard practice suggests a GFR of 5ml/minute or below as unacceptable for

even marginal existence. This level will correspond to a serum creatinine of 10 mg/dl in an average-sized individual with some variation in extremes of muscle mass. Certainly, some patients will need dialysis at a higher level of GFR if other

### TABLE 1 Indications for Dialysis in Acute Renal Failure

Fluid overload Hypercatabolism Level of BUN/creatinine Hyperkalemia Acidosis Uremia

### TABLE 2 Indications for Initiating Chronic Dialysis

Uremia
GFR 5ml/minute
Fluid and/or electrolyte imbalance
Acidosis
Hypertensive management
Neuropathy
Pericarditis

### TABLE 3 Symptoms of Uremia

Lethargy
Easy fatigueability
Anorexia, nausea, vomiting
Hiccups
Pruritis
Distal paresthesias, numbness

maladaptions are severe. Close observation for uremic symptoms is, thus, quite important. *Table 3* lists some of the more prominent symptoms. Unfortunately, the vagueness of these, coupled with their gradual development, makes recognition difficult for both the patient and the physician.

The lack of a finite end-point chemically and symptomatically makes repetitive testing, questioning, and examination necessary to avoid the potentially debilitating neuropathy or lethal pericarditis, the worst uremic results.

Peritoneal dialysis was first used some 30 years ago to support patients with chronic renal failure. The initial limitation was, as mentioned, access to the peritoneal cavity. A simple, relatively inflexible trochar can be used in the limited setting. Some more permanent device is required for long-term support. Several catheters are now available, all flexible for comfort and safety. Variability revolves around the major problems in chronic peritoneal dialysis-infection and lack of continued patency. Unfortunately, no catheter design has eliminated these problems, but even the simplest offers acceptable longevity to make chronic peritoneal dialysis a viable alternative to hemodialysis.

Intermittent peritoneal dialysis (IPD) is a variation of the technique described for acute renal failure. Repetitive, usually hourly, exchanges of dialysate are performed for 10 to 12 hours three to four times a week, using a machine for infusion. IPD has never made a large impact upon chronic dialysis because of the large time commitment and the tendency for inadequate dialysis. Only by increasing the length can removal be increased. Further time involvement is not acceptable to most patients.

In 1976 Popovich and Moncrief described a modification of chronic peritoneal dialysis for which they coined the term "Continuous Ambulatory Peritoneal Dialysis' (CAPD), a quite descriptive name. With this mode the patient can be completely ambulatory except when performing an exchange of dialysate. Fluid is nearly continuously present in the abdomen for diffusion and osmosis. Equilibrium between blood and dialysate does not occur for most solutes until 8 to 10 hours of exposure. Only during the exchange for fresh dialysate is transfer of wastes not proceeding. Three to five, usually four, such exchanges are carried out each and every day. The continuousness makes up for the low efficiency of peritoneal transfer.

Although no match for native kidneys, CAPD is nearly as efficient as hemodialysis with small molecular weight solutes such as BUN and creatinine, and

more so for larger so-called middle molecules, which may play a significant role in uremic toxicity, especially neuropathy.

The simplicity of CAPD is attractive for a number of patients. The lack of machines, not having to deal directly with blood, and no need for a helper are attributes for those living alone as well as others. It is a home therapy, freeing the patient for resumption of a more meaningful lifestyle. In addition, rapid fluid shifts do not occur, requiring less cardiovascular stability then hemodialysis. The diabetic with end-stage renal disease and older patients may benefit more from the development of CAPD than others for this last reason: the lack of need for systemic heparinization may lessen the risk of intraocular bleeding from neovascular diabetic retinopathy, a devastating potential with hemodialysis.

Infection remains a major complication, as well as a limiting factor in CAPD. The most benign type involves the area around the catheter, a so-called exit site infection. It often responds to oral antibiotics but can become indolent and even lead to removal of the catheter. Infection along the subcutaneous path of the catheter, a tunnel infection, is always serious, requiring catheter removal.

Finally, peritonitis can result from several mechanisms. Most cases are ac-

quired through contamination of the dialysate infusion pathway by the patient performing his or her exchange. Intraabdominal catastrophies such as diverticulitis may be more frequent in this group and can cause peritonitis. These processes will present with cloudy dialysate and abdominal pain and tenderness. Interestingly, fever is characteristically minimal or absent, and surprisingly little evidence of toxicity is seen. Fortunately, medical therapy is often successful with antibiotic addition to the dialysate and continuation of dialysis. Nearly one-half of the cases can even be treated on an outpatient basis.

Staphylococcus epidermidis is the most common contamination induced organism responding readily to cephalosporins. Gram-negative peritonitis may require aminoglycosides but still may be cleared medically, although less frequently than with staph. These as well as other less common skin organisms seem to be acquired through contamination the majority of the time. Peritonitis from fecal soilage is polymicrobial and more ominous. Surgical removal of the catheter can result from persistence of the peritonitis no matter what the organism. Staphylococcus aureus, pseudomonas, and fungi are the most frequent which lead to catheter loss. Following prolonged systemic antibiotics, the patient may be able to return to CAPD, barring extensive scarring.

Peritoneal dialysis in the form of CAPD has matured over the past five years into a viable alternative to hemodialysis for chronic support. These two modes of therapy should not be viewed as mutually exclusive but rather possessing special benefits for various types of patients and patient care situations. Together, hemodialysis and peritoneal dialysis offer relatively wide flexibility for patients with end-stage renal disease, as well as those with acute renal failure.

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# Diagnostic Ultrasound Imaging in Pregnancy

# A National Institutes of Health Consensus Report Synopsis

WILLIAM D. RAGAN, M.D. Indianapolis

Ultrasonography in pregnancy has become a highly developed technology capable of detecting many fetal structural and functional abnormalities. The marked increase in the use of ultrasound coupled with concerns regarding its safety and efficacy prompted the NIH report. The panel addressed the following questions:

- 1. What types of ultrasound scanning are currently used in obstetric practice? How extensive is this use? What is known about the dose/exposure to the fetus and the mother from each type? Exposure to imaging devices has been to static and real-time scanners. The percentage of pregnant women exposed to ultrasound examination ranges from 15 to 40% There are no data on the dose to either the mother or the fetus in the present clinical setting.
- 2. For what purposes is ultrasound now being used in pregnancy? For each use what is the evidence that ultrasound improves patient management and/or outcome of pregnancy? The following 28 obstetric applications were listed.

- Estimation of gestational age for patients with uncertain clinical dates, and for patients who are to undergo scheduled elective repeat cesarean delivery.
  - Evaluation of fetal growth.
  - Vaginal bleeding in pregnancy.
  - Determination of fetal presentation.
  - Suspected multiple gestation.
  - Adjunct to amniocentesis.
- Significant uterine size/clinical dates discrepancy.
  - Pelvic mass.
  - Suspected hydatidiform mole.
- Adjunct to cervical cerclage placement.
  - Suspected ectopic pregnancy.
- Adjunct to special procedures, such as fetoscopy, intrauterine transfusion, shunt placement, in vitro fertilization, embryo transfer, or chorionic villi sampling.
  - Suspected fetal death.
  - Suspected uterine abnormality.
- Intrauterine contraceptive device localization.
- Ovarian follicle development surveillance.
- Biophysical evaluation for fetal wellbeing after 28 weeks of gestation.
- Observation of intrapartum events (e.g., version/extraction of second twin, manual removing of placenta, etc.).
- Suspected polyhydramnios or oligohydramnios.
  - Suspected abruptio placentae.
- Adjunct to external version from breech to vertex presentation.
  - Estimation of fetal weight.
- Abnormal serum alpha-fetoprotein value.
- Follow-up observation of identified fetal anomaly.

- Follow-up for identified placenta previa.
- History of previous congenital anomaly.
- Serial evaluation in multiple gestation.
- Evaluation of fetal condition in late registrants for prenatal care.

The panel concluded that diagnostic ultrasound for pregnant women improves patient management in pregnancy outcome when there is an accepted medical indication.

- 3. What are the theoretical risks of ultrasound to the fetus and the mother? What evidence exists from animal tissue culture, and human studies on the actual extent of the risk? A number of epidemiological studies tend to support the safety of diagnostic ultrasound in humans. On the other hand, many studies reporting on the safety of diagnostic ultrasound in humans were considered inadequate.
- 4. Based on the available evidence, what are the appropriate indications for and the limitations on use of ultrasound in obstetrics today? It was the consensus of the panel that ultrasound examination in pregnancy should be performed for a specific medical indication.
- 5. What further studies are needed of efficacy and safety of use of ultrasound in pregnancy? The panel recommended its encouragement and support of a sustained research effort aimed at test systems that could help provide a better data base for developing reasonable estimates of bioeffects and of risk. It was thought that the question of ultrasound's contribution to reducing morbidity and mortality should be documented.

This synopsis is based on an N1H consensus development conference conducted in February 1984. Single copies of the complete consensus statement are available from Michael J. Bernstein, Office of Medical Applications of Research, Bldg. 1, Rm. 216, National Institutes of Health, Bethesda, Md. 20205.



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# Being Sensible About Salt

foods. It is added to canned, packaged, and frozen foods to flavor and preserve them. We add it during cooking. We sprinkle it on our meal at the table. It makes food taste good. And it is good for us—in limited amounts.

Salt is a necessary part of life, not only because it flavors and protects foods. Our bodies need sodium, which is present in salt, because it helps to maintain blood volume, regulate water balance, transmit nerve impulses, and perform other vital functions.

But many people consume far too much of it. Salt consists of 40 percent sodium and 60 percent chloride. One teaspoon of salt has 2 grams of sodium. The Food and Nutrition Board of the National Academy of Sciences believes that an adequate and safe level of sodium each day is 1.1 to 3.3 grams. Americans now consume between 2.3 and 6.9 grams daily.

Older people in particular should be cautious about using too much salt. The main reason for caution is that overuse of sodium is one factor that is associated with high blood pressure (HBP). Having a family history of HBP and being overweight are major factors too. HBP, in turn, can lead to heart disease, stroke, and kidney failure. Blood pressure rises with age, and all of these disorders are much more common among the elderly.

Restricting the amount of sodium in the diet helps lower HBP in many individuals who already have the disease. It also can increase the effectiveness of drug treatment, making a lower dosage possible.

As people grow older their sensitivity to flavors and smells usually decreases. Because of this, there may be a desire for more salt to combat the flat taste of foods.

If your doctor has suggested that you cut back on salt, there are several steps

you can take. It is easy to change a few dietary habits that will reduce the level of sodium without changing the diet drastically.

First, learn which foods in general contain less sodium. Fresh foods usually have less sodium that processed ones. Fresh meats, for example, are lower in sodium that processed ones such as lunch meats, bacon, hot dogs, sausage, and ham, all of which have sodium added to flavor and preserve them.

Likewise, most fresh vegetables are naturally low in sodium. Canned vegetables and vegetable juices usually have salt added, but some new lines are canned without it. Plain frozen vegetables without sauces are generally low in sodium. Fresh, frozen, and canned fruits and fruit juices are low in sodium.

Commercially prepared foods such as soups, frozen dinners, and other convenience items have salt added in their preparation. Some of these are available with substantially less sodium, so check the labels.

Snacks such as potato chips, pretzels, corn chips, popcorn, crackers, and nuts normally have a great deal of salt added and are best used sparingly.

When grocery shopping, look for low-sodium and sodium-free items. Many food manufacturers list the sodium content of their products on the labels. (Foods labeled "salt-free," "sodium-free," "low-salt," or "low-sodium" *must* have this information.) If sodium is one of the first three ingredients listed, the product is high in sodium.

When cooking meals at home, try to reduce gradually the amount of salt you use each day. And remember that adding salt is not the only way to flavor foods. You can also use lemon, pepper, herbs, spices, onion and garlic powders (not salts), powdered mustard, small amounts of sugar, finely chopped garlic, and fresh grated horseradish. Experiment with flavorings you haven't used before.

At the table, taste the food before adding salt. If you think the food needs some, add only a small amount.

Ketchup, mustard, relish, salad dressings, sauces, brines, and dips contain sodium. As your use of salt goes down, it may be tempting to use more of these. But go easy on them. Pickles and olives are also prepared with a considerable amount of sodium.

If food tastes more bland than it used to, try chewing it more thoroughly. Chewing breaks down food, allowing more molecules to interact with taste receptors in the mouth. It may also help to alternate bites of different foods. When you eat several bites of the same food, the flavor is stronger in the first bite than in the following ones.

Before using a salt substitute ask your doctor about it. These preparations usually contain potassium, which can be harmful to people with some medical conditions.

Many books on the subject of cooking with less salt are now available in libraries and stores. Newspapers and magazines often offer low-salt recipes.

When eating out, choose items that are less likely to have large amounts of salt added. Some restaurants will prepare low-sodium meals if asked to do so.

A single free copy of *Questions About Weight, Salt, and High Blood Pressure* is available from the High Blood Pressure Information Center, 120/80, National Institutes of Health, Box AP, Bethesda, Md. 20205.

A single free copy of *Sodium: Think About It* (529L) can be obtained by writing to the Consumer Information Center, Pueblo, Colo. 81009.

The Sodium Content of Your Food (138L) is available for \$4.50 from the Consumer Information Center, Pueblo, Colo. 81009. This booklet has tables showing the sodium content of common foods and nonprescription drugs.

From the National Institute on Aging, Food and Drug Administration.

ire prescribing, see complete prescribing information in F CO. literature or PDR. The following is a brief summary.

services is drug is not indicated for initial therapy of edema or pertension. Edema or hypertension requires therapy ated to the individual. If this combination represents the sage so determined, its use may be more convenient in tient management. Treatment of hypertension and edema not static, but must be reevaluated as conditions in each

raindications: Concomitant use with other potassium-ng agents such as spironolactone or amiloride. Further use uria, progressive renal or hepatic dysfunction, hyperkalemia ixisting elevated serum potassium. Hypersensitivity to either conent or other sulfonamide-derived drugs.

onent or other sullonamide-derived drugs.

Ings: Do not use potassium supplements, dietary or otherunless hypokalemia develops or dietary Intake of potasis markedly impaired. If supplementary potassium is
ed, potassium tablets should not be used. Hyperkalemia
occur, and has been associated with cardiac irregularities. It
are likely in the severely ill, with urine volume less than one
lay, the elderly and diabetics with suspected or confirmed
insufficiency. Periodically, serum k\* levels should be deterunderly and diabetics with suspected or confirmed
insufficiency. Periodically, serum k\* levels should be deterunderly and the develops, substitute a thiazide alone,
t k\* intake. Associated widened QRS complex or arrhythequires prompt additional therapy. Thiazides cross the
hatal barrier and appear in cord blood. Use in pregnancy
res weighing anticipated benefits against possible hazards,
ting fetal or neonatal jaundice, thrombocytopenia, other
se reactions seen in adults. Thiazides appear and trirene may appear in breast milk. If their use is essential, the
hat should stop nursing. Adequate information on use in
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his with or without a history of allergy or bronchial asthma.
The exacerbation or activation of systemic lupus erythesus has been reported with thiazide diuretics.

utions: Do periodic serum electrolyte determinations (par-

is with or without a history of allergy or bronchial asthma. Dele exacerbation or activation of systemic lupus erytheasus has been reported with thiazide diuretics.

Intitions: Do periodic serum electrolyte determinations (party important in patients vomiting excessively or receiving theral fluids, and during concurrent use with amphotericin B ricosteroids or corticotropin (ACTHI). Penodic BUN and in creatinine determinations should be made, especially in a derly, diabetics or those with suspected or confirmed renal sciency. Cumulative effects of the drug may develop in at swith impaired renal function. Thiazides should be used aution in patients with impaired hepatic function. They can state coma in patients with severe liver disease. Observe orly for possible blood dyscrasias, liver damage, other idioalize receiving triamterene, and leukopenia, thrombocyto-agranulocytosis, and aplastic and hemolytic anemia have reported with thiazides. Thiazides may cause manifestation in diabetes meliflus. The effects of oral anticoagulants may be recessary. Clinically insignificant cions in arterial responsiveness to norepinephrine have experiented. Thiazides have also been shown to increase the azing effect of nondepolarizing muscle relaxants such as a uranne. Triamterene is a weak folic acid antagonist. Do alic blood studies in cirrhotics with splenomegaly. Anti-ensive effects may be enhanced in post-sympathectomy at Such as a uranne. Triamterene is a weak folic acid antagonist. Do alic blood studies in cirrhotics with splenomegaly. Anti-ensive effects may be enhanced in post-sympathectomy at Such as a uranne. Triamterene is a weak folic acid antagonist. Do alic blood studies in cirrhotics with splenomegaly. Anti-ensive effects may be enhanced in post-sympathectomy at Such as a uranne. Triamterene has been reported in patients on de' when treated with indomethacin. Therefore, caution is do in administering nonsteroidal anti-inflammatory agents by azide'. The following may occur: transient elevated BUN sultinie or both, hy

des may add to or potentiate the action of other antihyper-

cs reduce renal clearance of lithium and increase the risk im toxicity.

im toxicity

Be Reactions: Muscle cramps, weakness, dizziness, headdry mouth; anaphylaxis, rash, urticaria, photosensitivity, a, other dermatological conditions; nausea and vomiting, a, constipation, other gastrointestinal disturbances; pospotension (may be aggravated by alcohol, barbiturates, cotics). Necrotizing vasculitis, paresthesias, icterus, atitis, xanthopsia and respiratory distress including pneusand pulmonary edema, transient blurred vision, sialaded vertigo have occurred with thiazides alone. Triamterene en found in renal stones in association with other usual is components. Rare incidents of acute interstitial nephritis een reported, impotence has been reported in a few on 'Dyazide', although a causal relationship has not stablished.

ed: 'Dyazide' is supplied in bottles of 1000 capsules; Unit Packages (unit-dose) of 100 (intended for institu-ise only); in Patient-Pak® unit-of-use bottles of 100.

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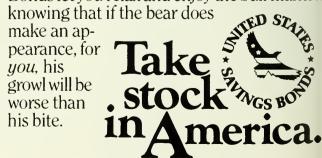
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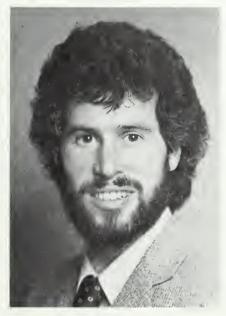
# TEFRA: How It Will Affect Your Retirement Plan

HE TAX EQUITY and Fiscal Responsibility Act of 1982 (TEFRA) has wrought major changes in the federal income tax rules governing retirement plans. Although these changes cover many areas, those with the greatest impact include: limitations on the maximum deductible plan contributions and benefits, limitations on loans to plan participants, rules for HR-10 (Keogh) Plans, required distribution rules, estate tax treatment of retirement plan benefits, income tax withholding on plan distributions and special requirements for topheavy plans.

1. Maximum deductible plan contributions and benefits have been significantly reduced, effective for plan years beginning after Dec. 31, 1982. Retirement plans can be divided into two major categories: defined contribution plans and defined benefit plans. A defined contribution plan provides for annual contributions based upon a percentage of the plan participant's salary. For example, a defined contribution plan may specify that the annual contribution will be 25% of each participant's salary. A separate plan account is maintained for each plan participant and it is credited with the employer's contribution and a pro rata share of the earnings (or losses) generated by the plan's investments. At retirement, the participant receives the balance in his/her account; thus, prior to retirement, the account balance at retirement is

The author is an employee benefit consultant who operates his own firm in Bloomington, Ind. He holds a bachelor's degree in Economics from Indiana University. His articles on employee benefit topics have appeared in *The Tax Advisor, The Journal of Pension Planning and Compliance*, and *The Journal of the Institute of Certified Financial Planners*.

Correspondence: P.O. Box 112, Bloomington, Ind. 47402.



PETER GOULD Bloomington

unknown, but the annual contribution rate is predetermined. Profit sharing plans, 401(k) plans, money purchase pension plans and target benefit pension plans are all classified as defined contribution plans.

The maximum contribution (per participant) to a defined contribution plan is now the lesser of \$30,000 or 25% of annual compensation. For unincorporated practices, the maximum limitation is now the lesser of \$30,000 or 20% of annual earned income.

A defined benefit plan provides for a predetermined monthly retirement benefit for each participant. The benefit is often based upon a combination of the participant's salary and service with the employer. For example, a defined benefit plan may provide for a retirement benefit equal to 3% of average salary for each

year of service. Thus, if a participant retires with 25 years of service and an average salary of \$80,000, he/she would be entitled to a monthly retirement benefit of \$5,000 ( $1/12 \times $80,000 \times 3\% \times 25$  years of service). Under this type of plan, separate plan accounts are not maintained for each participant. The annual plan contribution is determined actuarially; thus, the benefit at retirement is predetermined, but the year-to-year contribution is the unknown factor.

The maximum annual benefit under a defined benefit pension plan has been reduced to the lesser of \$90,000 or 100% of annual compensation. The maximum benefit is further reduced if retirement occurs before age 62.

- 2. Loans to participants are often permitted under corporate retirement plans. They are now limited to the lesser of \$50,000 or one-half of the participant's vested interest under the plan, but not less than \$10,000. All plans of an employer are considered a single plan for purposes of this limitation. Loans to sole proprietors, partners and shareholder-employees of Subchapter S corporations are still prohibited.
- 3. HR-10 (Keogh) Plans will benefit from TEFRA's changes. These plans are available to unincorporated businesses (either sole proprietors or partnerships). They are available as defined contribution plans or defined benefit plans. The (increased) contribution and benefit limitations have been listed above. Before TEFRA, it was required that a bank or insurance company be the trustee for such a plan. However, this is no longer required; you can be the trustee of your own plan and direct your own plan investments. These plans are now permitted to have a gradual vesting schedule to reduce retirement plan costs arising from rapid employee turnover. They can also

be integrated with Social Security benefits (to maximize the contributions/benefits for key employees).

4. Required distribution rules for "key employees" became effective for plan years beginning after Dec. 31, 1983. Most professionals and highly paid employees will fall under the definition of a "key-employee." These rules impose a 10% penalty tax on plan distributions made to a key employee before his/her attainment of age 59½, except in cases of disability or death. Also, a key employee must begin to receive plan distributions no later than the calendar year in which he/she reaches age 701/2, even if still employed. Finally, benefits payable in the event of death must be distributed from the plan within five years after the date of death, unless the beneficiary is your spouse. The Tax Reform Act of 1984 provided certain limited exceptions to these distribution rules.

- 5. The Federal Estate Tax exclusion for retirement plan benefits paid in the form of an annuity or in installments has been limited to \$100,000. Prior to TEFRA, there was no limitation on this exclusion and it often formed an important part of many estate plans. The Tax Reform Act of 1984 eliminated the \$100,000 estate tax exclusion, after 1984. For this reason, your estate plan should be reviewed and revised, if necessary.
- 6. **Income tax withholding** is now required for distributions from retirement plans, unless the recipient elects not to

have the withholding apply.

7. Special requirements for top-heavy plans will apply to plans in which the benefits for key employees exceed 60% of total plan benefits (such a plan is considered to be a top-heavy plan). If a plan is top-heavy, it is required to provide minimum contributions or benefits for all participants and it must also provide for more rapid vesting of a participant's benefits than a non-top-heavy plan.

Many of the major TEFRA changes are very complicated and technical. In the interest of clarity, some of the more technical rules have been omitted from the preceding commentary. Since the facts and details of all retirement plans are not identical, competent professional advice is highly recommended.



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# **PPO: Opportunity over Adversity**

HE GOLDEN ERA in the practice of medicine in this country is practically gone. The age of consumerism in all segments of our nation is rapidly unfolding. The consumers—the employees, the unions, the business and steel industry, the third-party payers—have started to realize that health care expenditure of \$1 billion a day is a situation that is no longer tenable and acceptable. The runaway cost of medical care is indeed making the health economy very sick.

The days when Dr. Smith could admit patients whenever he wanted to, order whatever tests he desired, keep the patients in the hospital as long as he or the patients wanted—whether because the patients did not have a ride home, or because it was more convenient for Dr. Smith to delay that discharge—are now gone. The hospital administrator who encouraged doctors to order more laboratory tests and x-rays, until the patient was glowing with or from radiation, has changed overnight. He now wants us to discharge patients as early as possible, sometimes earlier than what is medically proper. He now monitors how much laboratory utilization we do. He now realizes his big pocket will be empty if he does not operate efficiently.

One billion dollars a day in health care expenditures is indeed staggering, to say the least. Even physicians and other health care providers in the country agree it is.

There is enough blame to go around for all of us to share: the patients, who indiscriminately demanded medical care from their doctors . . . We, the "pro-

Presented at the recent organizational meeting of Comprehensive Healthcare Utilization Alternative, Inc., a new Preferred Provider Organization for northwest Indiana. Dr. Chua is the PPO's president and chairman. He is a member of the Critical Care Committee, American College of Chest Physicians.



FELIPE S. CHUA, M.D. Merrillville

viders," who succumbed to these whims and pressures . . . and at times kept the patients in the hospital longer than necessary, ordered a lot of tests in lieu of a good history and physical examination . . . The hospitals, who encouraged us to overutilize, and who charged whatever fees they wanted . . . The insurance carriers, who hiked their premiums and also delayed payments to the providers . . . The business industries, employers and unions, who supported the employees in their demand for more . . . and more and more . . . Some of our lawmakers, who passed laws that were illadvised just to get votes . . .

So, there is enough blame to share among all of us. If we are honest with ourselves, the situation should be apparent to all of us. This is not the time to point the finger at somebody else. It is the time to ask, "What can we do about this dilemma?"

They say that a pessimist is one who sees the hole in the donut; an optimist sees the ring of bread in a donut. A

pessimist sees difficulty in every opportunity; an optimist sees an opportunity in every difficulty.

I am an optimist, like many of you. I feel that out of this dilemma, something good can come, but that something good can only be achieved if, and only if, we organize ourselves into a united front.

I believe in the cliches, "United, we stand; Divided, we fall," or, "In unity there is strength." They may sound corny to some, but think about this: As physicians, who are the real consumers of hospitals, we can, as a united group, close any hospital we want, if we feel the hospital is not doing its job in maintaining quality medical care. All we have to do is to stop patronizing that institution. This has been done before and has been found effective. But I am not advocating this. All I am saying is that we as doctors, when united, can move mountains, if we want to.

Now, what is being done to alleviate the situation? Alternative forms of delivery of health care are coming into the picture. You have HMO, IPA, IPO PPA, PPO, DRG... etc. But do not allow your breakfast alphabet cereals to spell out which one is best for you. Because it might spell TNT or END for your practice. We have to know what they are, and decide which one with which we want to be involved.

HMO is certainly *not* the answer. HMO is more concerned with saving money. In this situation, quality of care suffers. We must, as guardians of the health care of our community, choose a system of delivery that will maintain quality care and at the same time be cost-efficient.

Since some types of HMO employ capitation, where the doctors are provided a certain amount per patient, the less money that is spent for that patient, the better for that doctor, and the more money he keeps. The weakness and fal-

lacy of the HMO is quite obvious here. We also feel that HMO is like V.A. medicine . . . and a lot worse. HMO is only a few steps away from socialized medicine, and only socialized medicine is worse than the HMO.

I was asked recently, "If HMO is that bad, why do patients like it? Why do business and industry like it?"

It is obvious. The public is gullible and not sophisticated enough . . . not informed enough . . . as a matter of fact, they are often deliberately misinformed to fall victims to the beautiful commercials on the radio, TV, or newspaper . . . about "HMO, the ideal health care system where you, the patients, do not spend a dime to get the best medical care in the world."

And the companies may choose HMO because they are concerned *first* about their finances. The companies that are concerned with *quality* care *first* will obviously not prefer HMO.

Let me relate an incident that actually happened in our area, just to illustrate a point.

A young girl was admitted with convulsive seizures. The pediatrician scheduled the child for a spinal tap. The coordinator of this HMO-type program called the pediatrician and questioned her about the indication for the spinal tap. "Are you a physician?" the pediatrician asked the voice at the other end of the phone. The coordinator said "No." "Then you do not have the right to question me and my medical judgment," said the upset pediatrician.

"Doctor, in that case, you will have to transfer the child to a hospital that participates in our program," the coordinator stated.

"This child is so sick, she may die. If you want to transfer her, you order her transfer yourself," the doctor angrily replied.

This is just one incident. And I am sure you have heard of more . . . and even worse.

The incursion into our medical practice and judgment by non-physicians, by those who are not our peers, must not be allowed. If we get organized and stop

being too independent for our own good, we still have a chance to preserve a good degree of free enterprise in the practice of medicine.

The rapidly changing practice of medicine in this country dictates unity among doctors, if we are to survive and enjoy our profession. We are at that point in the history of medicine when independence no longer means freedom. This is a time when independently, we shall fail; united, we have a better chance.

I am sure most of us in this room watch the news and weather forecast on television. While we do not believe that the forecast is I00% accurate, we know that to a great extent it is.

The same thing is true with the changing medical practice weather. When I attend meetings on alternative forms of health care delivery, and listen to our colleagues and friends in California, I can almost see the storm, the tidal waves, coming our way... in this direction. And the more I learn about it, the more I can sense it will be here. As a matter of fact, it is here. At the risk of sounding melodramatic, a calamity is fast approaching us.

We listen to the weather forecast because we would like to forearm ourselves when we leave home. If the forecast says rain is coming, we take our raincoat or umbrella. There are some indications the storm is closing in . . . and a little rain has already started. We need the best "raincoat" available.

The "raincoat" we are proposing is a PPO, Preferred Provider Organization, called the Comprehensive Healthcare Utilization Alternative. This is a corporation which was registered with the state of Indiana June 21, 1984, after two years of research and planning. When California passed a law in 1982 allowing for the formation of PPOs, we knew that the midwest would follow suit.

The main objective of this PPO is to provide cost-efficient, quality medical care to our community. We hope to achieve, among others, the following: (1) To preserve the free enterprise system in the practice of medicine in this area; (2) to maintain the fee-for-service form

of reimbursement; (3) To be approved and selected as the preferred providers of the major business companies and industries in northwest Indiana, and therefore improve the patient load of the members or the participants in this PPO;

- (4) To contract, through our chosen broker, with the businesses and industries in our area, provide them with say, 15-20% discount, like the other PPOs are doing in California and other states; (5) To benefit, as members of the Comprehensive Healthcare Utilization Alternative, by expeditious reimbursement of our professional fees, which could be paid within 7-10 days from the billing date;
- (6) To organize the doctors into a united group in order to have more clout in dealing with various segments in our community, including hospitals; (7) To safeguard the quality of medical care for the community by establishing and controlling a program that would be superior in providing quality care at a cost-effective level, as a preferred alternative to HMO, etc.;
- (8) To limit our membership to those health care providers who are sincerely interested in providing quality medical care in a cost-efficient manner. (Membership in this PPO is purely voluntary.); (9) To add more icing to the cake, and to benefit the employees directly, we could also provide 20% discount on their deductible or co-payment share.

This form of preferred providers alternative is actually happening now in many states. The only difference is that we are proposing, under the Comprehensive Healthcare Utilization Alternative, a PPO that is established and controlled by physicians, in contrast to those in other states which are organized and controlled by insurance carriers, business industries, unions or hospitals.

While we need to choose a broker and a marketing firm, to do the negotiations and contracting for us, the physicians, under our proposal, shall still have a great degree of control.

The Comprehensive Healthcare Utilization Alternative, Inc., has the blessing of the Lake County Medical Society and many segments of our medical community. While PPO is by no means a panacea, it is the best available alternative, which would assist us in achieving those goals enumerated above, as long as it is managed properly and efficiently.

Only doctors or providers who would practice good medicine, cost-effectively, will be accepted as members. The reason is simple. If our PPO is not able to contain cost significantly for the third-party payers by practicing good, efficient medicine, then they would eliminate us. The doctor-members, among themselves, should be strict with their utilization and peer review, etc.

In my meetings with the unions, insurance carriers and steel companies, they emphasize that while they are interested in cost savings and discounts, they are also interested in the quality of care.

I believe that, to maintain a semblance

of free enterprise in the practice of medicine—the fee-for-service system— and to assure quality medical care, doctors must run and control this PPO. Of course, we need to retain legal assistance, marketing firms and a broker to do the contracting for us, since it is illegal—antitrust—for us doctors to negotiate fees ourselves with the companies.

I do not want to mislead you into thinking that establishing and managing a PPO is easy. It is far from my intent to give you that impression. I have just summarized the problem, the cause, what alternative solutions there are, what we propose, and how to achieve our objectives. The actual logistics and mechanics, the details, etc... will certainly be 100% more complicated . . . and we will need expert help . . . a lot of expert help.

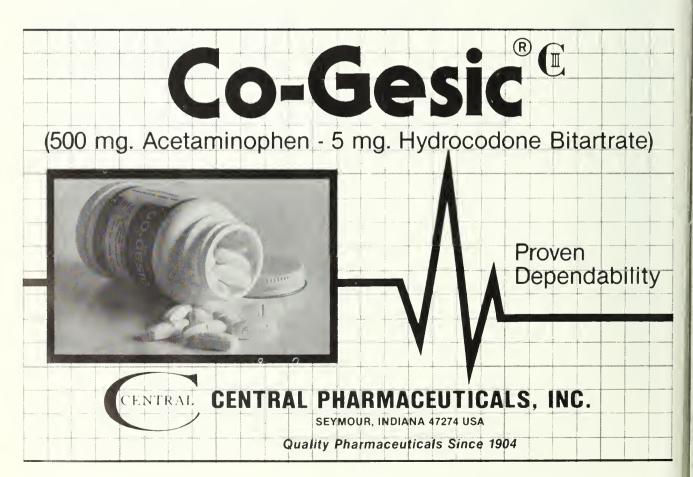
And this costs money. Yes, there will

be annual membership dues. How much it will be we still have to figure out.

Increasingly severe economic stress will affect hospitals and doctors over the next several years. Price competition and prospective payments have placed physicians and hospitals on a collision course. To survive, unified goals for patient care need to be developed by doctors and hospitals. Physicians will have to establish a very strong organization to address these issues effectively . . . for their mutual survival.

We need to prepare for the future, or we will be controlled by it. What we can do is to keep our eyes and ears open, project current trends, and design ways to respond effectively.

Now is the time to take action. Tomorrow may be too late. . . .



# Machines and Patient Care: Is Compassion Still Alive?

UESTIONS ABOUT whether or not physicians spend enough time caring for patients have been raised for years and have become particularly apt as medical technology and information mushroom and as the trend for medicine moves toward specialization. Recently, however, it appears that there has been a pendulum swing toward placing greater emphasis on the caring aspects of medical practice, both during the practice years and in the preparation of new physicians. That, at least, is the contention of the May-June 1984 issue of The Internist, the magazine of the American Society of Internal Medicine.

"The imbalance between the curing and caring functions (technology and humanism) . . . has come about because of an overemphasis on scientific matters in the education of physicians," suggests William Campbell Felch, M.D., editor of The Internist, in his opening remarks. "Medical school candidates are selected for their intellectual prowess, not their personal warmth. Both pre-med and medical school experiences are highly competitive and devoted to soaking up information. The residency years place major emphasis on the acquisition of technical skills; house officers frequently perceive those years as being fundamentally dehumanizing."

Medical students Calvin Cohen and Bruce Soloway agree with Dr. Felch's thoughts, explaining that "Students arriving on the wards in their third year of training soon learn the importance of knowing the available tests and technological interventions and of being appropriately eager to perform or to order them. . . . After all, although an honest exchange of information and caring between doctor and patient may produce an occasional 'gem' of a historical detail or physical finding, such interaction usually contributes little or nothing to the 'primary mission' of diagnosis and treatment.'

It would be a mistake, however, to conclude that technology is totally responsi-

A matter of humanism: Is your patient 'Joe Smith' or is he simply 'the guy with the fracture?'

ble for the "dehumanization" of the medical student or for the growing distance between doctors and patients in general, they go on to explain. Technology is merely an accomplice in the process; there are other reasons as well, including economic ones: First, empathetic communication is not reimbursable by third-party payers; second, procedures and tests generate more income for hospitals and practitioners than do extensive histories or exchanges of compassionate reassurance; third, physicians today face pressures to be more productive, to see more patients in less time and to spend less time with each patient; and fourth, patients have come to expect the "quick cure" by chemical or technological interventions.

But even within the present economic and technological contexts, there is much that *can* be done to sensitize physicians to their patients' emotional needs, and a major part of the responsibility for this effort rests on medical educators. Kathryn Hunter, Ph.D., assistant professor of Humanities in Medicine at the University of Rochester, believes that

while some medical students have an innate gift of compassion, others can be taught to be humanistic. It is up to the medical school admissions committee to cull from the pool of applicants those who are innately compassionate as well as those with the potential to learn that skill. Once the students are selected, Dr. Hunter continues, it is again the responsibility of the medical school to encourage the development and continuation of compassionate behavior.

Emphasis on caring shouldn't stop with the completion of medical school, however, according to Julius R. Krevans, M.D. In his article, Dr. Krevans outlines the efforts of the American Board of Internal Medicine (ABIM) to assess human qualities in professional behavior during residency training. Among the activities being conducted by the ABIM's Task Force on the Humanistic Oualities in the Internist are to identify the humanistic attitudes, habits and behavior that should be displayed in the internist and to identify those humanistic qualities an individual brings to the educational process and those qualities acquired in the educational

Richard S. Wilbur, M.D., secretary of the Accreditation Council for Continuing Medical Education, takes the idea one step further, examining the shifting balance in continuing medical education (CME) programs from those that emphasize the scientific aspects of medicine toward those that emphasize the human aspects. "The increasing number of CME offerings devoted to the patient as a human being rather than a case of disease is a restatement of the essential need for both aspects of healing," he concludes. "The resurgence of humanism in programs for practitioners reflects our acknowledgment of the unity of the human body."

From the American Society of Internal Medicine, 1101 Vermont Ave. N.W., Suite 500, Washington, D.C. 20005. Copies of the May-June issue of *The Internist* are available from ASIM for \$2 each.



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# 1984

# Indiana State Medical Association RESOLUTIONS

RESOLUTION 84-1

Introduced by: Miami County Medical Society

Subject: Physician Members of Hospital Boards of Trustees

Referred to: Reference Committee No.

Whereas, The laws of Indiana permit, however, do not require physician members on hospital Boards of Trustees; and

Whereas, Local communities have long established traditions of appointing nonphysician dedicated civic and business leaders to such boards; and

Whereas, Such members often lack prior knowledge and experience regarding the needs of the local hospital or in the field of health care; and

Whereas, Local physicians obviously possess the most authoritative knowledge and experience regarding the needs of the local hospital; and

Whereas, Economic and competitive factors mandate prudent management of hospitals today more than ever; therefore be it

<u>Resolved</u>, That the ISMA exert its strongest efforts to pass legislation to require at least one local physician voting membership on any tax supported hospital Board of Trustees.

RESOLUTION 84-2

Introduced by: ISMA Commission on Constitution and Bylaws

Subject: Committee Structure
Referred to: Reference Committee No.

Whereas, Expertise and interest from knowledgeable physicians enhances the activities of a committee; and

Whereas, The present committee structure of not less than 4 and not more than 5 members is limiting; therefore be it

Resolved, That Section 7.02 of the ISMA Bylaws be amended to read: Except as otherwise stated in the Bylaws, a committee shall consist of not less than five (5) members appointed from the general membership of the Association and shall be appointed annually by the President. (remaining portion of 7.02 is unchanged)

RESOLUTION 84-3

Introduced by: ISMA Commission on Constitution and Bylaws

Subject: Redefinition of Functions of the Executive Committee

Referred to: Reference Committee No.

Whereas, The 1983 Supplemental Report of the Chairman of the Board included a report of the ad hoc Committee to Study the Structure/Function of the Executive Committee (as per Resolution 81-1) requested amendments to the presently stated functions of the Executive Committee; therefore be it

Resolved, That Section 5.0601 final paragraph be amended by substitution to read, The authority and functions assigned by the Board to the Executive Committee shall be reviewed annually at the first regular meeting of the Board of Trustees; and be it further

Resolved, That Section 3.0401 final sentence be amended by deletion, [shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program]; and be it further

Resolved, That Section 4.0301 fourth paragraph be amended by deletion [at such time as may be arranged by the Executive Committee]; and be it further

Resolved, That Section 4.0305 last paragraph, final sentence be amended by addition, at least annually; and be it further

Resolved, That Section 4.0305 final sentence, last paragraph (as amended) becomes 6.0202 and all other sections and subsections be renumbered accordingly; and be it further

Resolved, That Section 6.01 be amended by addition to end of first sentence, from its voting members; and be it further

Resolved, That Section 6.01 be amended by deletion of all following the 3rd sentence; (final sentence - Its Secretary shall be the Executive Director of the Association.); and be it further

Resolved, That a new Section 6.02 be added and all following sections and subsections be renumbered accordingly (Quorums becomes 6.0201), 6.02 DUTIES: It shall meet with the Executive Director on the call of the Chairman, or of any three (3) members to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Director's office and such other duties as the Board may specify during the intervals between the meetings of the Board, and shall report its actions to the Board; and be it further

Resolved, That Section 6.05 be amended by addition, following the first 3 words, and with approval of the Board; and be it further

Resolved, That Section 7.1003 be amended by substitution, (5th sentence) The actions of this committee shall be certified to the Board of Trustees. (6th sentence) Each year a report of the Committee's activities, including a financial accounting report of the fund itself as administered by the trustee, shall be made a part of the Board Chairman's annual report to the House of Delegates; and be it further

Resolved, That Section 7.1008 be amended by substitution (next to last sentence first paragraph), The arrangements and the character of any and all technical exhibits must meet with the approval of the Board of Trustees of the Association. (last sentence, first paragraph) It shall, with the approval of the Board of Trustees prepare a program for scientific work for the Annual Convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the offices of the various sections, and it

shall with the approval of the Board of Trustees, arrange for scientific exhibits as a part of the Annual Convention; and be it further

Resolved, That Section 14.00 and its subsections be amended by substitution. Board of Trustees be substituted for Executive Committee throughout entire Section 14.00 and its subsections.

RESOLUTION 84-4

Introduced by: ISMA Commission on Constitution and Bylaws

Subject:

Duties and Responsibilities of Reduce Drunk Driving Committee

Reference Committee No. Referred to:

Whereas, The 1983 House of Delegates mandated a new Reduce Drunk Driving Committee; and

Whereas, The duties and responsibilities of said committee are hereby submitted to this 1984 House of Delegates for its approval; therefore be it

Resolved, That Section 7.0806 be added to the ISMA Bylaws, to read: The purpose of the Reduce Drunk Driving Committee is to reduce deaths and injuries to Indiana citizens due to drunk driving by 50% during the next 5 years and an additional 25% during the following 5 years. The unprecedented nature of this important commitment to the public requires that the Committee's activities be broad in scope.

RESOLUTION 84-5

Introduced by: ISMA Commission on Constitution and Bylaws

Duties and Responsibilities of Commission on Sports Medicine

Subject: Duties and Responsibili Reference Committee No.

Whereas, The 1983 House of Delegates mandated a new Commission on Sports Medicine: and

Whereas, The duties and responsibilities of said commission are hereby submitted to this 1984 House of Delegates for its approval; therefore be it

Resolved, That Section 7.1014 be added to the ISMA Bylaws, to read: The Commission on Sports Medicine shall provide liaison between the ISMA and various athletic organizations. The Commission will research issues and make recommendations in a variety of areas relating to sports medicine in our state, in an attempt to improve the medical care of Indiana athletes and related personnel.

RESOLUTION 84-6

Introduced by: ISMA Commission on Constitution and Bylaws

Subject:

Article III--ISMA Constitution--Component Societies

Referred to: Reference Committee No. Resolved, That Article III--Component Societies, be amended to read: Component societies are those county, district or other medical societies as specified in the bylaws contained within the state of Indiana, and who hold charters from this Association.

RESOLUTION 84-7

Introduced by: Resident Medical Society

Subject: ISMA Bylaws Section 12.

ISMA Bylaws Section 12.03--Intern and Resident Medical

Society (IRMS)

Referred to: Reference Committee No.

Whereas, The position of medical intern no longer exists in Indiana; and

Whereas, The term Intern is used throughout Section 12.03 and its subsections; therefore be it

Resolved, That the word Intern(s) be deleted in Sections 12.03, 12.0301, 12.0302, 12.0303, and 12.0304 of the ISMA Bylaws; and be it further

Resolved, That the name of this organization shall be the Resident Medical Society (RMS) of the Indiana State Medical Association.

RESOLUTION 84-8

Introduced by: Resident Medical Society

Subject: Resident Medical Society Representatives

on the ISMA Board of Trustees

Referred to: Reference Committee No.

Whereas, The Resident Medical Society is a newly organized and chartered component society of the Indiana State Medical Association; and

Whereas, The members of the Resident Medical Society practice in and train in different areas throughout the state of Indiana and therefore do not fall in the category of any one district; and

Whereas, Resident physicians have concerns different from those of other practicing physicians; and

Whereas, More effective communication and interaction are desired between resident physicians and the leadership of the Indiana State Medical Association; therefore be it

Resolved, That the Resident Medical Society should have one full-voting member represent the Society on the Indiana State Medical Association Board of Trustees.

RESOLUTION 84-9

Introduced by: Resident Medical Society

Subject: Resident Medical Society Representation

in the ISMA House of Delegates

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Referred to: Reference Committee No.

Whereas, The Resident Medical Society has been established as a component society of the Indiana State Medical Association; and

Whereas, Members of the Resident Medical Society are dues-paying members of the Indiana State Medical Association; and

Whereas, Members of the Resident Medical Society are presently physicians-in-training and present and/or potential members of county medical societies; and

Whereas, County medical societies presently are allotted one delegate to the ISMA House of Delegates per fifty members and fraction thereof; and

Whereas, The Resident Medical Society presently is allotted only one delegate and one alternate delegate to the ISMA House of Delegates, regardless of the number of members; therefore be it

Resolved, That the representation of the Resident Medical Society in the ISMA House of Delegates be one delegate per fifty members and any fraction thereof, in a manner consistent with the present system used for county medical societies.

RESOLUTION 84-10

Introduced by: Ramon Dunkin, M.D., President, Indiana Society of Internal

Medicine

Michael A. Hogan, M.D., Chairman, Indiana Chapter, American

Academy of Pediatrics

Charles W. Hachmeister, M.D., President, Indiana Academy of

Family Physicians

Subject: Cognitive Services Reimbursement

Referred to: Reference Committee No.

Whereas, All physicians (regardless of specialty) provide a mix of both cognitive and procedural services; and

Whereas, Cognitive services can be defined as those services that directly employ the physicians' perception, judgment and knowledge to find out what is wrong with the patient and to decide the best course of treatment; and

Whereas, Technological procedures involve the use of technology and/or manual skills to obtain clinical data or to treat disease; and

Whereas, Most existing reimbursement systems provide disproportionately low allowances for such cognitive services as complete histories and physical examinations, office, nursing home and hospital visits, and medical and surgical consultations in comparison to procedural services; and

Whereas, Many technological procedures also require considerable cognitive skill and judgment on the part of the physician providing the procedure; and

Whereas, The cognitive skills required to provide those procedures are also reimbursed at a disproportionately low level compared to the actual performance of the procedure; and

Whereas, This reimbursement discrepancy may contribute to high medical care costs by rewarding physicians for ordering tests and procedures, and by penalizing them for spending time with patients and deciding not to order costly procedural services; and

Whereas, There is a growing body of opinion and research to support the concept that a reimbursement system that better rewards cognitive services might help moderate medical care expenditures and promote the kind of caring, personalized approach to health desired by most patients and physicians alike; therefore be it

Resolved, That the Indiana State Medical Association support the concept that third party payors should provide more equitable reimbursement for physicians' cognitive services in comparison with their procedural services; and be it further

Resolved, That the Indiana State Medical Association take appropriate action to promote this concept with third party payors, business groups and other professional associations.

### RESOLUTION 84-11

Introduced by: ISMA Executive Committee

Subject: Future ISMA Convention Locations

Referred to: Reference Committee No.

Whereas, The Board of Trustees of ISMA on October 20, 1980 took action, "That for future planning the annual meeting be held every other year in Indianapolis, and if possible, rotating the meeting on a north and south basis in alternate years; and

Whereas, This recommendation has been followed with a successful meeting in Evansville in 1983; and

Whereas, Future meetings are planned for South Bend in 1985, French Lick in 1987, and Merrillville in 1989; and

Whereas, The one distinctive drawback of meetings in noncentralized locations is the necessity for many physicians to travel greater distances to attend the annual convention; and

Whereas, Lack of close and immediate access to ISMA records in the headquarters office from time to time obstructs immediate background information requests of reference committees and the House of Delegates as they deliberate; and

Whereas, Transporting staff to distant convention sites adds more to the total cost of the convention; therefore be it

Resolved, That following the annual convention in South Bend in 1985 all future annual conventions of ISMA be held in Indianapolis and Marion County or in other areas adjacent to or in close proximity to the Indianapolis area.

### MEETING SCHEDULE:

Oct. 19-22, 1984 Radisson Plaza, Indianapolis

Oct. 11-14, 1985 Century Center and Marriott Hotel, South Bend

Oct. 31 - Nov. 3, 1986 Hyatt Regency, Indianapolis

Oct. 30 - Nov. 2, 1987 French Lick

Nov. 4-7, 1988 Adams Mark, Indianapolis
Nov. 1989 Holiday Plaza, Merrillville

### RESOLUTION 84-12

Introduced by: ISMA Section on Directors of Medical Education

Subject: Payment for Health Care Services

Referred to: Reference Committee No.

Whereas, A special feature of the American system for the payment of health care services has been its inclusion of certain costs of health professions education and health research in the payment for health services; and

Whereas, The public needs well trained committed health professionals; and

Whereas, Research provides the basis for improving the quality of health care; and

Whereas, Withdrawal of financial support could have undesirable consequences; and

Whereas, Withdrawal of financial support could also alter the makeup of individuals entering the health professions, therefore be it

Resolved, That payment systems should help support health professions education and some forms of research.

### RESOLUTION 84-13

Introduced by: ISMA Executive Committee

Subject: Uniform Dues Reimbursement Policy

Referred to: Reference Committee No.

Whereas, Resolution 67-6 instructed ISMA to establish a system of computerized billing for the collection of all dues and for distribution of those dues separately to the respective societies; and

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Whereas, ISMA has received requests from both county and district societies for special reimbursement procedures; and

Whereas, Special reimbursement procedures present both an administrative drain and a financial drain for ISMA; therefore be it

Resolved, That ISMA establish a uniform dues reimbursement policy that provides for ISMA distributing county and district dues on a monthly basis and that those checks be mailed within ten days of the close of each month's business.

### RESOLUTION 84-14

Introduced by: ISMA Executive Committee

Subject: Dues Increase

Referred to: Reference Committee No.

Whereas, The breadth and depth of ISMA activities and programs continue to escalate in proportion to the increasing necessary involvement of organized medicine in legislation, public relations, member communications and governmental affairs, all designed to defend the individual physician's freedom to practice quality care; and

Whereas, The economy has experienced a cumulative rate of inflation of 76% since 1975, the last year of a dues increase for ISMA members; and

Whereas, The fiscal 1983-84 budget contains a forecast of a \$35,000 deficit; and

Whereas, The budget projection for fiscal 1984-85 will be substantially greater; and

Whereas, The special \$25 dues increase, authorized for a two year period by the 1982 House of Delegates "to pursue all avenues, including litigation if necessary regarding our opposition to health insurance programs requiring participation agreements and to establish a fund for promotion of medical philosophy and principles" becomes void at the end of fiscal 1984; and

Whereas, The percent of ISMA income derived from dues is 54% with the balance coming from investments and other non-dues sources; therefore be it

Resolved, That effective January 1985 ISMA dues be increased \$54.00 to two hundred thirty-five dollars (\$235) per year to establish a solid monetary base for ISMA's continued growth and effective impact on anticipated and unanticipated changes in the medical care delivery system.

### RESOLUTION 84-15

Introduced by: Resident Medical Society of the Indiana State Medical

Association

Subject: Resident Medical Society Representation on ISMA Commissions

Referred to: Reference Committee No.

Whereas, Physicians-in-training and young physicians-in-practice represent a growing proportion of the physicians in organized medicine; and

Whereas, The Resident Medical Society has been established as a component society of the Indiana State Medical Association to represent physicians-in-training; and

Whereas, The Resident Medical Society is not a part of any region represented by an ISMA trustee medical district; and

Whereas, Each medical district is allotted at least one member on each commission of the Indiana State Medical Association; and

Whereas, Physicians-in-training are not represented on ISMA commissions; and

Whereas, Resident physicians have concerns different from those of other practicing physicians; therefore be it

Resolved, That the ISMA President appoint at least one resident physician to each commission of the Indiana State Medical Association.

### RESOLUTION 84-16

Introduced by: 12th District Medical Society

Subject: Increasing Supply of Physicians

Referred to: Reference Committee No.

Whereas, The number of graduating physicians has increased to the point of meeting the physician/population needs; and

Whereas, Physician over population creates a condition leading to under utilization of talents; and

Whereas, It does not appear that a solution to this problem has been sought vigorously at an official licensure level; therefore be it

Resolved, That the Medical Licensing Board of Indiana be requested to actively seek an appropriate solution to this potential problem and communicate these actions back to the Indiana State Medical Association.

### RESOLUTION 84-17

Introduced by: George T. Lukemeyer, M.D., President, ISMA

Subject: Medical Staff Section
Referred to: Reference Committee No.

Whereas, Recent changes in the delivery of health care and its reimbursement have increased the complexity of medical staff functions and responsibilities; and

Whereas, The American Medical Association has formed a Medical Staff Section to respond to these changes in the medical care environment; therefore be it

Resolved, That the Indiana State Medical Association follow the leadership of the American Medical Association and form an Indiana Hospital Medical Staff Section; and be it further

Resolved, That the Indiana State Medical Association encourage all hospitals in the state to send an elected representative to both state and national meetings of said section.

### RESOLUTION 84-18

Introduced by: ISMA Board of Trustees

Subject: Medical Practice Law Revision

Referred to: Reference Committee No.

Whereas, The Indiana Medical Practice Law does not require any graduate medical education in an accredited program in the U.S. prior to taking the Indiana FLEX examination; and

Whereas, All graduates of LCME and AOA accredited schools and non LCME and non AOA accredited schools may take the Indiana FLEX examination if proof of graduation is considered valid; and

Whereas, graduates of non LCME and non AOA accredited schools exceed the number of graduates of LCME and AOA accredited schools taking the Indiana FLEX examination and have a poorer pass record; and

Whereas, If graduates of non LCME and non AOA accredited schools pass the Indiana FLEX examination they are granted a provisional license to practice in Indiana for a period not to exceed two years and must serve under the "preceptorship" of a county medical society or a hospital medical staff; and

Whereas, the terms "preceptor" and "preceptorship" as expressed in the medical practice law do not convey the intent of the law regarding supervision rather than education causing confusion in the interpretation and implementation of that provision of the law; and

Whereas, the new FLEX I and FLEX II examination requirements of the Federation of State Licensing Boards are to be implemented in June 1985; therefore be it

Resolved, That that portion of the Indiana Medical Practice Law which specifies that foreign medical graduates (graduates of foreign medical schools) who have not completed two years of postgraduate training prior to passing the Indiana FLEX examination must agree to practice under the preceptorship of a county medical society or hospital medical staff be deleted; and be it further

Resolved, That all reference to foreign medical graduates be deleted and replaced by the term "graduates of non LCME or non AOA accredited schools"; and be it further

Resolved, That to be eligible to take the FLEX I examination all candidates must have evidence of the completion of all the requirements to receive their M.D., D.O. or equivalent degree from a non LCME or non AOA accredited school; and be it further

Resolved. That FLEX I must be passed by the candidate prior to the completion of PGY I in an accredited program; and be it further

Resolved, That to be eligible to take FLEX II the candidate must have successfully passed FLEX I and successfully completed PGY I in an accredited program; and be it further

Resolved, That the Indiana Medical Licensing Board be fully advised of the aforementioned plans and recommendations.

LCME = Liaison Committee on Medical Education

AOA = American Osteopathic Association

FLEX = Federation Licensing Exam

PGY = Post Graduate Year

### RESOLUTION 84-19

Introduced by: Carroll County Medical Society

Subject: Meeting Days of ISMA Anna Referred to: Reference Committee No. Meeting Days of ISMA Annual Convention

Whereas, At present the ISMA annual meeting is scheduled for Friday through Monday; and

Whereas, Monday is the busiest day in many practices; therefore be it

Resolved, That the annual meeting of ISMA be changed to a Thursday through Sunday format.

### RESOLUTION 84-20

Introduced by: Fountain-Warren County Medical Society Chairman of the Executive Committee Subject:

Referred to: Reference Committee No.

Whereas, In corporate organizational structure usually the Chairman of the Board of Trustees serves as Chairman of the Executive Committee; and

Whereas, In this organization the Executive Committee regularly reports and is accountable to the Board of Trustees; and

Whereas, The Chairman of the Board should be most able to direct the Executive Committee and to report any actions taken to the Board; therefore be it

Resolved, That the Chairman of the Board also serve as Chairman of the Executive Committee.

RESOLUTION 84-21

Introduced by: Fountain-Warren County Medical Society

Subject: Annual Meeting Site
Reference Committee No.

Whereas, The Executive Committee has introduced Resolution 84-11 dealing with this subject; and

Whereas, The reasoning in support of the resolution is extremely sound; and

Whereas, There is an exception for the 1985 annual meeting before the policy is adopted and instituted; therefore be it

Resolved, That the policy of a central annual meeting site take effect immediately and the 1985 site be returned to the Indianapolis area.

RESOLUTION 84-22

Introduced by: Marion County Medical Society

Subject: Review of Regulations
Referred to: Reference Committee No.

Whereas, The Indiana State Medical Association is charged with the study of and response to legislative and regulatory proposals as to their effect upon the practice of medicine and the protection of the public health; and

Whereas, The Indiana State Medical Association is charged with keeping "the profession informed at all times concerning its area of responsibility;" and

Whereas, Substantial regulations affecting the delivery of medical and health service have been and are being promulgated under statutory authority by a variety of agencies without being brought to the attention of component societies and members; therefore be it

Resolved, That an appropriate body within the Indiana State Medical Association conduct a thorough evaluation of health-related agencies promulgated and proposed (1983 to present) regulations with regard to their impact on the protection of the public health and consistency with the statutory authorities under which these regulations have been or may be proposed; and be it further

Resolved, That progress reports on these efforts be made on a monthly basis to component societies.

RESOLUTION 84-23

Introduced by: Marion County Medical Society
Subject: Clarifying Generic Substitutions

Referred to: Reference Committee No.

Whereas, The Indiana State Medical Association supported generic substitution legislation to assist the citizens of Indiana in obtaining lower cost pharmaceutical products when medically appropriate; and

Whereas, Clinical effectiveness of generic drugs due to differences in bio-availability of their contents is recognized by physicians, despite the drugs being chemically equivalent; and

Whereas, The best clinical results for patients may be obtained through the physicians' consideration of these differences in generic drugs; and

Whereas, The interest of the public is not served by advertising and other presentations which diminish the differences among generic drugs; therefore be it

Resolved, That the Indiana State Medical Association undertake programs to better inform the public regarding the substantial differences which may have adverse consequences on the therapeutic effect of generic drugs.

### RESOLUTION 84-24

Introduced by: Marion County Medical Society
Subject: Closing of Staffs and Services

Referred to: Reference Committee No.

Whereas, The freedom of choice available to patients can be detrimentally affected by the limitations of alternatives available to physicians rendering services in a hospital situation; therefore be it

Resolved, That the Indiana State Medical Association oppose efforts by any hospital which serves to limit physicians' free choice and competitive alternatives through the closing of Medical Staffs, Sections of Medical Staffs, or which limit physician access to services based on arbitrary objectives which do not clearly enhance patient care.

### RESOLUTION 84-25

Introduced by: Howard County Medical Society

Subject: Suggested Name Change from Impaired Physicians

Committee to Distressed Physicians Committee

Referred to: Reference Committee No.

Whereas, The name of Impaired Physicians Committee implies a determination of impairment before an actual evaluation has been accomplished; and

Whereas, The intent of the committee, either county or state, is to deal with distressed physicians before impairment has occurred; and

Whereas, Early intervention is more conducive to assistance or remediation; therefore be it

Resolved, That the name of the local, county and state Impaired Physician Committees be changed to Distressed Physician Committee.

RESOLUTION 84-26

Introduced by: Fort Wayne Medical Society

Subject: Consumer Protection Division, Office of Attorney General

Referred to: Reference Committee No.

Whereas, The Indiana Law (Indiana Code Section 25-1-7-5) requires that complaints coming to the Consumer Protection Division of the Office of Attorney General, State of Indiana, and concerning licensees of the Medical Licensing Board, State of Indiana, must be forwarded to the Medical Licensing Board for resolution of the complaint through negotiation; and

Whereas, These complaints have and will continue to be forwarded to the Medical Licensing Board after negotiation, resolution and/or decision by panel or trial on the complaint has already taken place; and

Whereas, These complaints to the Medical Licensing Board take valuable time away from other important duties that are required of the Medical Licensing Board; therefore be it

Resolved, That the Indiana State Medical Association take appropriate action to change and/or modify the Indiana Code to exempt physicians from the jurisdiction of the Consumer Protection Division, Office of Attorney General in those instances where the complaint against the physician has been resolved previously.

RESOLUTION 84-27

Introduced by: Clark County Medical Society
Subject: Free-Standing Emergency Centers

Referred to: Reference Committee No.

Whereas, Officials of several hospital associations and other independent medical groups have expressed intent to purchase, build, or subsidize "free-standing" emergency centers; and

Whereas, Presently there are no state regulations provided by the Indiana State Board of Health to govern and monitor their operation; and

Whereas, Use of the words "emergency" or "urgent" in the names of such centers may cause patients with true life-threatening emergencies to be present there inappropriately and with tragic consequences; and

Whereas, free-standing emergency centers generally do not provide for continuity of patient care which may further fragment the delivery of medical services and lessen the quality of care for the patient; therefore be it

Resolved, That the Indiana State Medical Association Commission on Legislation review the matter of the regulation of both hospital and medical group-sponsored free-standing emergency centers and draft legislation for introduction into the Indiana General Assembly which would broadly define and regulate the utilization of similar terms and words associated with "emergency centers".

RESOLUTION 84-28

Introduced by: Vanderburgh County Medical Society

Subject: Uniform Dues Reimbursement Policy to Counties

Referred to: Reference Committee No.

Whereas, Resolution 67-6 instructed ISMA to establish a system of computerized billing for the collection of all dues and for distribution of those dues separately to the respective societies; and

Whereas, Vanderburgh County Medical Society has complied with that system to date; and

Whereas, ISMA reimburses county dues to county medical societies by different arrangements resulting in inequities in the amount of interest earned by county medical societies; and

Whereas, Vanderburgh County Medical Society would like the ability to bill for special dues categories and to acknowledge receipt of dues in a timely manner; therefore be it

Resolved, That ISMA establish a uniform dues reimbursement policy that provides for ISMA reimbursing county and district dues to each respective society within thirty (30) days of receipt, revise the billing form to permit special county dues categories, and send an acknowledgment of receipt of dues to the member on behalf of Vanderburgh County Medical Society and ISMA.

### RESOLUTION 84-29

Introduced by: Section on Preventive Medicine & Public Health

Subject: Funding of Basic Public Health Services

Referred to: Reference Committee No.

Whereas, There is an increasing need and demand for public health services, many of these services are mandated by federal and state legislation, and are implemented by local health departments; and

Whereas, There has been a long standing problem of adequate funding for county health departments, depriving many citizens of essential basic health services; and

Whereas, The Indiana Association of Public Health Physicians is preparing legislation to address these financial problems; therefore be it

Resolved, That the ISMA support legislation for state funding of local health jurisdiction and approve the principle of state funding for all basic public health services; and be it further

Resolved, That this House of Delegates direct the ISMA Commission on Legislation to support said legislation.

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The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

### Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with *Motrin* Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

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Good medicine...good value

### Motrin" Tablets (ibuprofen)

**Contraindications:** Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets. **Precautions: Blurred and/or diminished vision**, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets, use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

*Motrin* Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever. As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.). *Motrin* should be discontinued.

**Drug interactions.** Aspirin. used concomitantly may decrease Motrin blood levels.

Coumarin: bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers

**Adverse Reactions:** The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,\* epigastric pain,\* heartburn,\* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); Central Nervous System: Dizziness,\* headache, nervousness; Dermatologic: Rash\* (including maculopapular type), pruritus, Special Senses: Tinnitus; Metabolic/Endocrine: Decreased appetite, Cardiovascular: Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship\*\*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests, Central Nervous System: Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia, Special Senses: Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAU-TIONS); Hematologic: Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit, Cardiovascular: Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations, Allergic: Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); Renai: Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria, Miscellaneous: Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown\*\*

Gastrointestinal: Pancreatitis; Central Nervous System: Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri, Dermatologic: Toxic epidermal necrolysis, photoallergic skin reactions; Special Senses: Conjunctivitis, diplopia, optic neuritis; Hematologic: Bleeding episodes (e.g. epistaxis, menorrhagia); Metabolic/Endocrine: Gynecomastia, hypoglycemic reaction, Cardiovascular: Arrhythmias (sinus tachycardia, sinus bradycardia); Allergic: Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; Renal: Renal papillary necrosis

\*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

\*\*Reactions are classified under "Probable Causal Relationship (PCR)" if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under "Causal Relationship Unknown" if seven or more events have been reported but the criteria for PCR have not been met.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthrifis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t i.d. or q i.d. Do not exceed 2400 mg per day. Mild to moderate pain. 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription.

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# EDITORIALS

### **Early Dietary Habits**

Dietary habits established in childhood are very likely to extend into adulthood. Infants fed on low-salt and unsweetened baby food do not develop a preference for these additives and are able to enjoy diets without salt and sugar later in life. Another dietary component may soon be added to the list. The American Institute for Cancer Research reports that Cornell researchers are convinced that certain nutrients promote tumor growth and others inhibit it. Several scientific groups have concluded that, based on the evidence available, dietary guidelines to lower cancer risk are warranted.

Fat is what they are talking about now. Dr. Colin Campbell, Professor of Nutritional Biochemistry at Cornell University, in speaking in Indianapolis to the American School Food Service Association, recommended that diets for school children be reduced in fat content from the average of 40% down to 30% and preferably lower. The percentage of fat is calculated on the ratio of fat calories to total calories. Dr. Campbell also recommended making up the decrease in calories, caused by lowering the fat content, by increasing the amount of fruits, vegetables and whole grain cereal products.

### **Bystander CPR**

"A bystander who knows cardiopulmonary resuscitation (CPR) can mean the difference between life and death for a heart attack victim." The American College of Emergency Physicians opens a press release with the above statement and follows with several pieces of good advice from an article in the August issue of Annals of Emergency Medicine.

The thrust of the release is that, since the most frequently encountered indication for CPR is heart attack, most of the CPR instruction is given to the wrong age bracket. CPR students average age 33. Heart attack victims are almost always over 40 and many are many years over 40. The advice is that CPR instruction be given to people of all ages and, in particular, in the case of those over 40, to the people who are associated with them at home and at work.

Another good suggestion in the Annals

article is made by the author, William B. Carter, Ph.D., who has developed a training course for emergency dispatchers who, it has been demonstrated, are able to give instructions by phone to the emergency caller, which facilitates the untrained caller to perform CPR immediately.

King County (Washington) now has a telephone CPR program. Now, anyone in that county who witnesses a cardiac arrest may provide emergency care immediately, instead of waiting for outside help during the critical first few minutes.

Heart attacks, of course, are not the only causes of cardiac arrest. Lightning is one of the several causes and there are other traumatic events such as auto accidents that may stop your ticker. Accidental electrocution by high voltage currents occur rather commonly.

In fact, everyone from teenagers on up should have a good course in CPR and regular reviews in the process. Some industries limit the number of CPR trainees in their factories and offices to a manageable number who can be given regular up-to-date retraining and review courses on a periodic basis. Retraining is important, just as important as the primary training.

### Fads and Novelties

### Guest Editorial

One interesting feature of practice experience is the fun of watching medical fads and novelties come and go and, hopefully, not being caught up in each one as it waxes and wanes.

I am not advocating cigarette smoking for pregnant women, or anyone else. Considering the present medical hoop-la about smoking by pregnant women, I smile a bit as I recall that many of the doctors who are in their 30s and 40s were born in the era when large numbers of women of child-bearing age smoked lots of cigarettes whether they were pregnant or not. One wonders whether that is what is the matter with some of our doctors; personally, I doubt it.

In dealing with obstetrics and newborn infants, one of the "new" ideas of today is "bonding" of infant and parent. It is presented as such an important concept. As nearly as I can determine, the idea is

a take off on the observation that newly hatched goslings and ducklings tended to "bond" to the first moving creature in sight and follow it as though it were the parent. Such ludicrous sights as a duckling trying to secure "mothering" from a dog or a human were portrayed in news media pictures. I never made such experiments so I am not an authority on the subject, nor am I in a position to call such ideas "hoaxes."

I am aware that during the 1930s and the I940s, and through most of the 1950s, most of the mothers giving birth in our hospitals were given large doses of sedatives during labor, and general anesthesia at the time of delivery. The mothers became aware that they were no longer pregnant several hours after their babies had been resuscitated and taken to the nurseries. The mothers learned the sex of the infant three-eight hours after the birth. During those times, the babies were kept in the nurseries except for being brought to the mothers for feeding during mother's waking hours. Fathers rarely touched the infant until the day of discharge.

Until the 1940s, mothers stayed in the hospital at least 10 days following delivery. Many of our present-day doctors were born under such a system. Is that one of our problems today? Did we become "bonded" to the female figures in scrub dresses who changed our diapers in the nurseries instead of to our maternal ancestors?

Many other concepts and ideas are worth our pondering. Step therapy of hypertension with the first step being thiazides; jejuno-ileal surgery for obesity; coronary bypass surgery in tens of thousands of cases each year. Some of the disease-of-the-month-club selections of historic interest were the indiscriminate labeling of chronic brucellosis, hypoglycemia, focus of infection, and proscription of estrogenic hormones for postmenopausal women. Many others can be added to the list by any good doctor who is over the age of 40.

I believe the admonition about being neither the first nor the last to try new therapies is attributed to Doctor Osler. Maybe he knew something that some of us have not learned, or have forgotten.—L.A. Arata, M.D., Shelbyville



# AUXILIARY REPORT

Judy Koontz (Mrs. James A.) President, ISMA Auxiliary

Erma Bombeck has written of a dream she had that every volunteer in the country, disillusioned with the lack of compassion, had set sail for another country. She passed quiet hospitals where there were no flowers in patients' rooms. The home for the aged was "like a tomb." The infirm sat in wheelchairs that would never move. Social agencies had their doors closed, health agencies cancelled research, alcoholics cried out in despair. She fought in her sleep to catch a glimpse of the ship again, because "it was to be my last glimpse of civilization . . . as we were meant to be."

We can't let this happen. We don't think you would want it to happen either. Dear Doctor: The ISMA AUXILIARY needs your Spouse!! We need an interested, active, caring, and informed membership. Auxiliary wants to: help educate people to take care of their health; assist with legislative issues involving health care; and, be supportive of medical families' needs. "Together we can make a difference."

There are many rewards for being ac-

tive in programs that serve the communities in which we live. Our members belong to the Auxiliary because they can be of service; because they can keep informed; and, because they can work for fair legislation involving health matters. If your spouse is not a member, won't you encourage her/him to join today? Our membership committee is willing and eager to assist in any way. Your county society should encourage the formation of an auxiliary if you do not have one at this time. Can we assist you?

### ATTENTION, ATTENTION, MEDICAL FAMILIES

We hope to see your medical family at the ISMA Fall Convention in Indianapolis at the Radisson Hotel on October 19 to 22. There are activities planned for the spouses on Saturday morning. Auxiliary Day is on Sunday, October 21, with lunch planned at the Woodstock Country Club. See you there!!

Membership forms the base for our AUXILIARY RAINBOW. We must strive daily to keep a strong base—a strong membership—for our healthy RAINBOW. Other aspects of our RAINBOW are as follows: green equals AMAERF fund raising; yellow equals health projects; orange equals legislative activities; and red equals our theme, "MAKE SOMEONE HAPPY BY CARING AND SHARING." We hope to have a colorful year with something of interest for everyone with a pot of gold at the end!

Auxiliary's goals for this year are as follows:

- 1. To assist the ISMA with health-related projects
- 2. To increase our membership
- 3. To increase county participation in our state-wide health project called "An Early Start to Good Health"
- 4. To provide leadership training for county officers and chairmen
- 5. To encourage and assist county auxilians as they participate in health related endeavors in their home communities

### INDIANA STATE MEDICAL ASSOCIATION AUXILIARY Executive Committee

President Judy Koontz (Mrs. James A.) Vincennes	Recording SecretaryMartha Stout (Mrs. Francis E.)  Muncie
President-Elect	TreasurerMary Jo Gutwein (Mrs. Gilbert) Lafayette
1st Vice President Alfrieda Mackel (Mrs. Frederick) Huntertown	Past President
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# EXTRA! EXTRA!

# READ ALL ABOUT HOW DOCTORS CAN HELP INFLUENCE

THE DECISIONS OF CONGRESS AND THE STATE LEGISLATURE REGARDING MEDICAL ISSUES!

THEN... Please complete the form which appears in this publication and return the form promptly. Don't pass up the chance to help determine the direction of medical practice in The United States.

The American Medical Association and The American Medical Association Auxiliary want to ensure that medicine continues to have a positive effect on the political process. They are combining efforts to conduct a national voter registration called PRO-JECT MEDVOTE. This is a bi-partisan effort designed to ascertain what physicians, spouses and voteable age children are registered to vote and to make being registered easier for them. MAKING YOUR VOTE COUNT IS PART OF RESPONSIBLE MEDICAL CITIZENSHIP. You cannot vote however, if you do not have an up to date registration.

In Indiana, we are doing our best to have a deputy registrar representing each of the two major political parties from each county medical society and/or auxiliary, and through them, to help all members of the medical families to be registered to vote.

We are fortunate that in Indiana, we can have deputy registration in the home and at medical functions. WE NEED YOUR HELP IN ORDER TO DE-TERMINE WHAT MEMBERS OF THE MED-ICAL FAMILIES ARE REGISTERED OR NEED TO BE REGISTERED. REMEMBER: Registration in the home or at a location other than the County Court House can be done until September 27. You can still register after that at your County Court House or designated voters registration location until October 6th. If a child will have become eighteen (18) by Election Day (November 6, 1984) he/she may register to vote and vote. If you will have moved between the last election and November 6, you must transfer your registration. If you have not voted within the last two years, your name has probably been purged from the records and you must reregister.

STAND UP AND BE COUNTED! Please complete the information form appearing in this publication. Indiana is known for interest in politics and good government. With the information which you supply us, we will do our best to get you registered. Remember, however, the final effort is your responsibility. 350,000 A.M.A. members and Auxiliary plus spouses, family and employees = 1,000,000 eligible voters. THAT'S VOTING POWER.

PLEASE COMPLETE THIS FORM AND RETURN PROMPTLY TO: MRS. DWIGHT W. SCHUSTER = 6510 N. CHESTER AVE., INDIANAPOLIS, IN 46220



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### OB-GYN-PEDIATRICIAN TEAM

New Hospital Opening in Fall of 1984 in Fulton, Missouri

This represents an outstanding medical practice opportunity. County of 30,000 primary service area with fine small community of 12,000 + hosting two nationally known colleges and a growing industrial base. We are close to the Lake of the Ozarks as well as multiple other recreational opportunities and facilities. The Hospital has a fine tradition of strong family-practice physicians and has recently recruited an orthopedic surgeon to build its surgical team to two. There are over 400 births in this County each year, and the pediatric population is growing steadily. Residents want the best in specialist medical care.

For further information regarding guarantees or other considerations contact

Robert M. Spille, Administrator, Callaway Community Hospital, Hospital Drive, Fulton, MO 65251, 314-642-3376.

# CME QUIZ.

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: Indiana University School of Medicine, CME Division, Fesler Hall 224, 1120 South Dr., Indianapolis 46223.

### Child Safety Seats

CONTINUED FROM PAGES 775-779

- A mother comes with her child for a checkup with you. Upon questioning her, you find out that she has a car seat. She then describes it to you as one that hooks under the back of the seat, "sits up nice and high," collapses, and has "a nice armrest for him to rest his arms." You
  - a. Check the back of the seat to see if the seat has been crash-tested or if the date of manufacture was after Jan. 1, 1981.
  - b. Have her contact the manufacturer to see if the seat meets federal safety
  - c. Suggest that she put her child in a seat belt until she can determine if the seat is safe.
  - d. Suggest that she make a cover for the seat so that the seat's vinyl does not get too hot.
- e. Do everything but "d."
- In order to determine if parents are using a car seat correctly, you would ask them:
  - a. Where they have put the car seat belt on the seat (i.e., through the frame, around the seat).

- b. If required, is the seat's tether strap attached correctly?
- c. Do they use the seat's internal harness straps and/or shield as indicated?
- d. Is the seat reclined at a correct angle?
- e. Which way is the child facing in the car?
- f. All of the above
- 3. Parents frequently complain that children do not like their safety seats. What is the best advice you might give parents to help alleviate problems they may be having?
  - a. Tell the child he will have to sit in the seat, because if he doesn't, he might get killed.
  - b. Tell mom and dad to strap the child in and ignore the noise.
  - c. Suggest that they purchase special toys for the child to play with only in the
  - d. Practice using the seat on short trips and gradually increase the lengths of the trips until the child is comfortable.
  - e. c and d.
- A new mother is ready to leave the hospital. She has borrowed a car seat from the hospital and has been instructed

- on its proper use. You notice that she has placed the car seat front facing in the rear seat. You should:
- a. Congratulate her for obtaining and using a car seat.
- b. Explain the importance of infants riding rear-facing and supervise the proper installation of the seat.
- c. Take the seat out and put it back in properly yourself, seat belt and all.
- d. Ask a nurse to re-install the car seat while giving mom further instruction.
- e. Make mom get out her instruction sheets, read them, and do it over
- 5. Indiana's child passenger safety law requires that children from birth to age 5 ride in a car seat.
  - a. True
  - b. False
- For a safety seat to be considered properly used, it must meet which of the requirements listed below:
  - a. The seat must have been manufactured after Jan. 1, 1981.
  - b. The seat must be fastened to the seat of the car with a seat belt.
  - c. The seat must be used with whatever internal harness system is part of the
  - d. The seat must be reclined correctly according to the manufacturer's instructions.
  - e. All of the above.

**CONTINUED ON PAGE 830** 

### SEPTEMBER CME QUIZ Answers

Following are the answers to the CME quiz that appeared in the September 1984 issue: "Diagnosis, Evaluation and Treatment of the Child with a Simple Febrile Seizure," by Philip F. Merk, M.D. and John E. Heubi, M.D.

1. b 6. b 2. a 7. b 3. d 8. a 9. a 4. b 10. b 5. d

Answer	sheet	for	Quiz:	(Child	Safety	Seats)	,
					_		

1. a b c d e

6. a b c d e

2. a b c d e f

7. a b

3. a b c d e

8. a b

4. a b c d e

9. a b c d e

5. a b

10. Clip & Attach Question 10.

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association, I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of Indiana | plication before Nov. 10, 1984 to the address appearing at the top of MEDICINE for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for this month's quiz, send your completed, signed ap-

# BOOK REVIEWS

### Control Your High Blood Pressure Without Drugs

By C. M. Bennett, M.D. Copyright 1984, Doubleday & Company, Inc., New York. 392 pages, hardcover, \$15.95.

Control Your High Blood Pressure Without Drugs! is beamed primarily at persons with elevated blood pressure. The volume is targeted secondarily at physicians, especially over-prescribers. The author urges—indeed pleads—that proper diet, rational exercise, and control of stress largely replace the use of drugs in managing essential hypertension. He would not, however, completely eliminate medication for proper indications, even though the title of the book implies otherwise.

This well qualified author attributes hypertension to varying combinations of excessive sodium intake, stress, susceptibility (perhaps genetic), and time. His approach includes a change in lifestyle, including elimination of nicotine in all forms, avoidance of caffeine, and judicious (if any) use of alcohol.

He supports his thesis with numerous anecdotes, placing particular emphasis on the numerous untoward effects of the usual medications employed in treating hypertension, as well as the side effects of sedatives, laxatives, and the like. The author's sincerity and dedication shine through when he says, "Sometimes I feel like Paul Revere trying to awaken a sleeping populace."



"Most of my money is invested in postage—trying to collect my fees from the Government and patients!"

In his spelling out of the serious, even disabling side effects of diuretics, the "blockers" (chiefly beta-blockers), vasodilators, other antihypertensive drugs, and additional medications, the pictures he paints are bleak-and considerably more realistic than the information presented in the PDR. This reviewer does feel, however, that Dr. Bennett is not justified in placing such low side effect beta-blockers as nadolol and atenolol in the same boat with propranolol. (But his indictment of propranolol coincides exactly with this reviewer's experience.) Another cavil: the low-sodium diet required to achieve the effect wrought by diuretics is impractical, if not impossible. (This reviewer knows!) But, as the author asserts, it is fatuous to take a diuretic and not energetically restrict sodium at the same time.

The book is divided into an Introduction, "The Program," Readings, and Appendices. "The Program" is a series of exercises covering 12 weeks and comprises a sound psychosomatic approach to minimizing stress.

This well written book, which sells for \$15.95, is enthusiastically recommended for patients with essential hypertension, ideally after a few words of guidance from their physicians. Its approximately 400 pages provide much of value for patients and physicians alike, especially those physicians who rely too heavily on medication.

W. D. Snively, Jr., M.D. Evansville Internal Medicine

# Surgery of the Musculoskeletal System

C. McCollister Evarts, M.D., chief editor, 4 volumes. Copyright 1983, Churchill-Livingstone, New York. \$250.

This is a very comprehensive text containing chapters by approximately 150 orthopedic specialists from all over the United States. There are ninety-six pages of subject index in each volume, but no author index. The material is presented under twelve main headings, each with a separate editor, and each containing from seven to twenty-five chapters. In the preface Dr. Evarts, Chairman Department of Orthopedics of Rochester

University School of Medicine and Dentistry, states that "the purpose of this book is to present in one source the information needed to assess, plan, and perform a surgical procedure on the musculoskeletal system of the adult." Considering the galaxy of stars assembled to get the four volumes together one would judge that his task has been accomplished well.

Physicians of Indiana will be interested to learn that Dr. Donald B. Kettelkamp, chairman of the Orthopedic Department of Indiana University School of Medicine. is Editor of the section on "The Knee", comprised of fourteen separate chapters. Because of recent improvements in ligamentous reconstruction of the knee and total joint replacement at times with prosthetic devices this is an important chapter. Dr. William M. Capello and Terry R. Trammel, also of Indiana University Medical Center, present chapters on "The Indiana Conservative Hip Arthroplasty" and "Operative Treatment of Adult Scoliosis", respectively.

Indiana physicians, especially those in Richmond, will have a special interest in the chapter on "Management of Adult Osteomyelitis" of which Jon T. Mader, M.D., son of John H. Mader of the Reid Memorial Hospital staff of Richmond, Indiana is co-author. Jon's principal research work has been on the use of oxygen in hyperbaric chambers for anaerobic infections, which, of course, are common in osteomyelitis. He and his co-author correctly point out the necessity for establishing as completely as possible the location and extent of the infectious process and the need for good debridement and surgical removal of necrotic tissue. Properly chosen antibiotic therapy must often be accompanied by hyperbaric oxygen exposure for optimum results.

This set of volumes will be of value to all surgeons and those especially involved in sports medicine. For orthopedic surgeons it will probably prove to be indispensable.

Paul S. Rhoads, M.D. Richmond Internal Medicine

# Current Pediatric Diagnosis & Treatment

8th Edition, edited by C.H. Kempe, M.D., H. K. Silver, M.D., and D. O'Brien, M.D. Copyright 1984, Lange Medical Publications, Los Altos, Calif. 1,164 pages, softcover, \$27.

The 8th edition of Current Pediatric Diagnosis & Treatment is indeed current. It represents an update of the 7th edition published only two years ago. The text is beamed at a wide spectrum of health professionals involved in the care of children. As was the case with previous editions, most of the contributors are present or former members of the faculty of the pediatrics department of the University of Colorado School of Medicine. This fact in itself represents an enormous plus for the volume since the department in question is one of the world's finest, both in research and in its clinical application.

In addition to the thorough revision of the entire book, the chapters on adolescence and on emergencies and accidents have been completely rewritten. An intriguing new chapter on dysmorphology (birth defects) has been added. It includes such subheads as "Interacting Systems in Terato-genesis," "A Classification of Dysmorphic Features," "Drug-Related Disorders," "A Clinical Approach to the Dysmorphic Infant," and, finally, a helpful "Protocol for Decision Making."

The text is appropriately and adequately illustrated and is sturdily bound. I recommend it enthusiastically for everyone involved in pediatrics, family medicine and related specialties.

W. D. Snively, Jr., M.D. Evansville Internal Medicine

**Dell Publishing** has a paperback entitled *Pickles and Ice Cream: The Complete Guide to Nutrition During Pregnancy.* The authors are Mary Abbott Hess, R.D., M.S. and Anne Elise Hunt. The book is endorsed by Dr. Spock. \$6.95.

**Dell Publishing** has issued a paperback edition of *Feed Your Self Right*. The author is Lendon Smith, M.D., a best-selling author, internationally known for his nutritional guidance. The book evaluates all types of disorders associated with each stage of adulthood and suggests remedies and preventives for each in an easy-to-comprehend manner. \$7.95.

West Publishing has a new book, Medical Proof of Social Security Disability, written by Dr. David A. Morton, a senior medical consultant with the Arkansas State Agency for Disability Determination. Dr. Morton shows what must be included in the medical record and how a claim may be rejected because of wording. He explains the exact wording of the official SS Impairment Listings and how to apply them to the claim. He also shows how a patient may qualify for benefits even if disability fails to meet any listing. He helps to break down common medical terms into terms that attorneys and administrators understand and arranges them in a glossary. 585 pages, \$52.50.

Care Institute announces Alcohol in America: The Price We Pay. The author is Rashi Fein, Ph.D., a Harvard Medical School economist. He advocates increases in the amount of government and insurance spending on alcoholism prevention and treatment. He estimates the cost of alcohol abuse to America as high as \$120 billion per year. Dr. Fein states that an enlarged investment in alcohol treatment could actually shrink overall health care costs. \$8,95.

### An Ounce of Prevention

Suggestion: Do not create unreasonable expectations about the results of treatment.

Discussion: On the surface, this recommendation may seem to be a frivolous one since it could be presumed that prudent physicians and surgeons would refrain from such self-serving dialogue with their patients.

However, contrary to this logical assumption, an examination of claim files reveals that this is one of the most frequently made, formal allegations against policyholders in certain specialty areas:

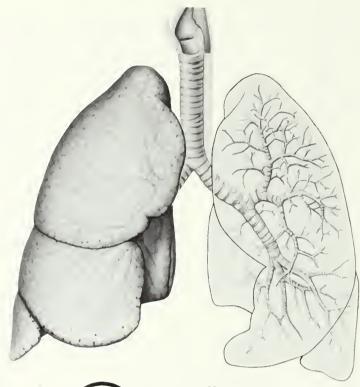
 Neurosurgery: Laminectomy—guaranteeing improved athletic abilities or complete relief from pain.

Defense recommendation prepared by the Medical Liability Mutual Insurance Company, New York, N.Y.

- Orthopedic Surgery: Fracture care—guaranteeing full use of extremity with no restriction.
- Plastic Surgery: Elective cosmetic surgery—guaranteeing a new lease on life, beauty, etc.
- Ophthalmology: Cataract surgery—guaranteeing perfect vision.
- Ob/Gyn: Tubal ligations—guaranteeing no further pregnancies.
- Urology/General Surgery: Vasectomy—guaranteeing sterility.

These allegations, whether based in truth or fabricated, can be, if not eliminated, at least legally squelched if a doctor maintains meticulous record of pre-treatment discussions with patients on the potential hazards of each procedure.

# Consider the causative organisms...



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H. influenzae, H. influenzae, S. pneumoniae, S. pyogenes (ampicillin-susceptible) (ampicillin-resistant)

Briet Summary Consull the package literature for prescribing information

information
information
information and Usage Cector\* (celactor Litly) is indicated in the
treatment of the following infections when caused by susceptible
strains of the designated microring anisms
Lower respiratory infections, including pneumonia caused by
Streptococcus periumoniae (bliphococcus preumoniae) Haemoph
istis influenziae, and S. progenes (group A beta-hemolytic
streptococcus).

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Contraindication Declor is contraindicated in patients with known altergy to the cephalospoint group of antibotics. Warrings IN PENICIL IN. SENSITIVE PATIENTS, CEPHALO-SPORIN AN INBIDIOES SHOUL OB EA MOMINISTER OCAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDIONS ANAPHYL AXIS. TO BOTH ORUCE CLASSES.

Antibotics, michigo Geology, should be administered cautiously to any patient who has been ceptically or with high patient who has been ceptically and patient who has been ceptically and patient who has been ceptically and the proposition of the patient of the proposition of the patient of

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colinis does not improve after the drug has been in discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colinis produced by C difficile. Other causes of colinis should be ruided out

produced by C difficile. Other causes of colitis should be rivided out.

Precautions General Precautions — It an altergic reaction to Ceclor' releafor. Litily occus, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g. pressor animes, annihistamines, or corticosteroids. Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. It superinderion occurs during therapy appropriate measures should be taken.

Beasures should be taken. Should be the compared the presence of the compared to th

colitis
Usage in Pregnancy — Pregnancy Calegory B — Reproduction
studies have been performed in mice and rats at doses up to 12
times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cector' (cetacior Livly). There are, however, no adequate and well-controlled studies in prepnant women. Because animal reproduction sludies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. \*\*Musring Mothers\*\*—Small amounts of Cector have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml.al two, three, four, and tive hours respectively. Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Cector is administered to a musting woman.

Usage in Children — Salety and effectiveness of this product for use in inlants less than one month of age have not been established

We will also share the control of th

of the syndrome Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy Other effects considered related to therapy included essingshital in 50 patients), and genial privitius or vaginitis (less than 1 in 100 patients). Causar Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain entology they are listed below to serve as alerting information for the physician phosphatase values (1 in 40) Hemalopoetic — Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children 1 in 40): Renal — Slight elevations in BUN or serum creatinine lless than 1 in 500) or abnormal urinalysis (less than 1 in 200). [6617828]

Note Cector\* (cetaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to pencillin-allergic patients. Pencillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxs of rheumatic tever's See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46285 Eli Lilly Industries, Inc Carolina Puerto Rico 00630

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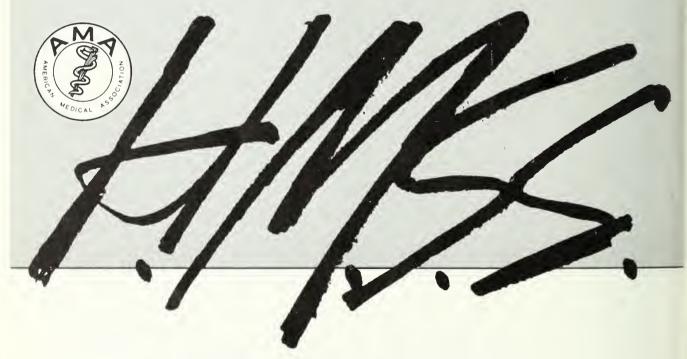
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# news notes.

### News from the AMA

- A special task force on professional liability has been created by the AMA board of trustees. It will be chaired by James H. Sammons, M.D., executive vice-president. In testimony before Congress, the AMA said the average incidence of claims has risen from 3.3 per 100 physicians before 1978 to 8.0 per 100 physicians in the period from 1978 to 1983. Trustee James S. Todd, M.D., said the AMA's Committee on Professional Liability reports that "no segment of litigation has had a more rapid growth during the past 15 years than claims emanating from health care."
- Medical licensing boards will be notified by the AMA when a physician loses his license for incompetence. The AMA is concerned that physicians who have been found unfit to practice in one jurisdiction are able to relocate and practice in another jurisdiction where they hold a license, Using the AMA Physician

Masterfile, the AMA will send information on a disciplinary action in one state to all other states where the physician has held a license.

• The voluntary fee freeze is supported by 73% of physicians, according to a study commissioned by the AMA. Based on 775 telephone interviews with a random sample of physicians, the AMA estimated that the one-year halt to fee increases would save Americans about \$1.41 billion.

### Asthma Handbook

The American Lung Association, with the aid of a grant from Key Pharmaceuticals, has published *The Asthma Handbook*, a new self-help guide for adults with asthma. Key will distribute the book to physicians for use in office practice. The ALA will also distribute it nationwide through local Lung Association offices.

### I.U. Sets Up DNA Bank

The Department of Medical Genetics at the 1.U. Medical Center campus in Indianapolis has established a DNA bank, the first of its kind in the world.

DNA is extracted from the white cells of approximately one ounce of blood drawn from a donor's vein. There are more than 3,000 known genetic diseases. In order for medical geneticists to help families who face the risk of inheriting and passing on one of these conditions, the DNA of each family is preserved for tests presently available and for tests discovered in the future. Each deposit of DNA will be available only to the donor or another responsible member of his or her family.

There are limited resources for banking DNA of individuals who cannot afford the banking costs. The DNA bank is supported by the 1.U. School of Medicine, the Hereditary Disease Foundation, chapters of the Huntington's Disease Foundation of America and a bequest from the Lena Marcus Trust of New York City.

### CME Quiz . . .

CONTINUED FROM PAGE 823

- 7. If parents place their 2-year-old in a federally approved booster seat, they are violating the requirements for restraint of young child passengers indicated by Indiana law.
  - a. True
  - b. False
- 8. If parents place their 2-year-old in a booster seat equipped with a tethered harness system in the back seat of the car, they can use just the lap belt to restrain the child in the seat.
  - a. True
  - b. False
- 9. You are told by parents that they only have a two-passenger motor vehicle. The mother intends to carry her newborn infant in her arms on their trip home from the hospital. They tell you that this is their only means of transportation and that they cannot buy another car. There is a fold-down armrest between the two bucket seats in their car. They ask you if they could use a safety seat in this area. Your best response(s) in this situation:
  - a. A safety seat cannot be installed in an area where there is no seat belt and the seat back that the child faces must be padded its full height.
  - On-lap travel is extremely dangerous and places small infants and children in a position for serious injury or death.

- Indiana law requires that an infant be placed correctly in a federally approved safety seat.
- d. At least for the ride home from the hospital, the parents should trade cars with a relative or friend that would seat more than two passengers.
- e. All of the above.
- 10. Match the answers below with the correct terms:

### Answers

- 1. Seats used for children from birth to 40 pounds.
- 2. Straps inside safety seats that contain child in the seat.
- 3. Part of the harness system that is usually a large plastic padded piece that protects the child's midsection.
- 4. A padded tray that is not part of the internal harness system.
- 5. Seats used for children from birth 10 20 pounds.
- Strap that comes off the back of the sear that must be attached to an anchor plate directly behind the seat.
- 7. Used on lap-shoulder belts to help secure safety seat to seat of car.

### Terms

- \_\_\_\_Armrest
- \_\_\_\_Convertible
- \_\_\_Tether strap
- \_\_\_Harness system
- \_\_\_Locking clip
- \_\_\_Shield

### **Diagnostic Imaging Study**

A study recently completed by the Medical College of Wisconsin indicates that under prospective reimbursement the reduction in conventional imaging testing, resulting from the introduction of CT, can produce savings that will significantly offset the cost of CT acquisition. Such savings may allow the 50- to 200-bed community hospital to provide CT services at a price that is competitive with larger urban hospitals, according to a press release prepared by the Medical Systems Group, General Electric Co., Milwaukee.

The 10-month study of the diagnostic imaging needs of a random sample of Wisconsin community hospitals without CT concluded that institutions could amortize the capital and operating costs of an advanced CT scanner by providing just over 900 procedures a year and charging about \$300 per examination.

The in-depth study, which covered eight of 49 Wisconsin hospitals in the 50-to 200-bed range that have more than 2,000 admissions per year, was aimed at helping the medium size community hospital to more effectively plan to meet its diagnostic imaging needs.

### **DES Daughter Loses Suit**

A diethylstilbestrol manufacturer was entitled to a directed verdict in a product liability action, a federal trial court in South Dakota has ruled.

In an action by a DES daughter, the manufacturer moved for a directed verdict on the ground that the patient had no evidence that it knew of the adverse reaction in 1949 when her mother took the drug.

Granting the motion for a directed verdict, the trial court said the manufacturer had no duty to warn of adverse reactions it did not know of or should not have foreseen.—*McElhaney v. Eli Lilly & Company*, 575 F. Supp. 228 (D.C., S.D., Nov. 25, 1983).

(A previous decision in this case was reported by the AMA in *The Citation*, Vol. 49, No. 2, p. 20.)

### **Drug Overdose Treatment**

Activated charcoal, taken by mouth, is reported to function as an effective treatment for drug overdose. A recent article in *JAMA* told of a young woman who had ingested large doses of terbutaline sulfate and theophylline. The serum theophylline half-life fell significantly after administration of oral activated charcoal, 50 g, every six hours.

### **Alcoholism Retreat**

Koala Centers, alcohol and drug abuse treatment centers in Lebanon and Columbus, will sponsor a two-day retreat Oct. 20-21 with Claudia Black for adult children of alcoholics. It will be at the Holiday Inn in Columbus.

Ms. Black, a nationally known lecturer and television personality, is the author of *It Will Never Happen to Me* and *My Dad Loves Me—My Dad Has a Disease*.

For information, call Ron Brown at (317) 844-7070 or Candace Backer at (812) 376-1711.

### Cigarette Safety Act

The House of Representatives passed H.R. 1880, the Cigarette Safety Act, on Aug. 6. The Senate has before it a similar measure, S. 1935.

The House bill establishes an Interagency Committee to oversee the work of a technical group that will study ways to develop a cigarette with a "minimum propensity to ignite upholstered furniture or mattresses."

More than 60,000 residential fires a year are attributed to cigarettes, and cigarette-ignited fires resulted in more than 2,100 deaths in 1981, making cigarettes the number one cause of fire deaths in the United States.

# Humanitarian Award Created

The directors of Reid Memorial Hospital, Richmond, have established an award recognizing unusual contributions to health care by a physician.

The Rhoads Humanitarian Award is named for Dr. Paul S. Rhoads, director of medical education at the hospital.

The honoree must be a resident of Reid's service area and meet at least one of nine specified criteria. These achievements include serving as an example of humanitarianism in medicine, providing leadership and increasing public understanding of health care.

### 'Law for the Medical Office'

The American Association for Medical Assistants has published "Law for the Medical Office" and a workbook to accompany the text. "Law for the Medical Office" is a comprehensive introduction to a complete subject. Suitable for both home study and classroom learning, it is a complete course, composed of a text and workbook with two self-scoring examinations.

For complete information in regard to price schedules for the two books, write the Association at 20 N. Wacker Drive, Chicago 60606, or phone (312) 899-1500.

### - Physician Recognition Awards -



The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.



Atassi, Bassem, Merrillville Boyd, Carl R., Logansport Brillhart, James R., Indianapolis Brown, Earl R., Indianapolis Coutz, Marla, Cicero Cowen, Richard L., Evansville Eastlund, Marvin E., Fort Wayne Echsner, Herman J., Columbus Engel, Howard R., South Bend Fortuna, Frank W., Beech Grove Graf, Russell E., Syracuse Gregory, David L., Columbus Harper, James W., East Chicago Haswell, John N., Vincennes Kephart, Stewart B., Bluffton Ko, Benny S., Terre Haute Larson, Michael S., Munster Lee, Lorin L., Indianapolis Marley, Carma M., Indianapolis Marquinez, A. A., East Chicago Mason, Earl J., Gary Matherly, Ryan D., Elkhart

Miranda, Conrado R., Winchester Morone, Ralph P., Indianapolis Patel, Shodhan L., Munster Patel, Suresh M., Connersville Pierce, Gene S., Floyds Knobs Pierce, William J., Merrillville Shah, P. N., Fort Wayne Silvers, L. M., N. Manchester Stegemoller, Ronald K., Danville Ungemach, Willo F., Fort Wayne Zia-Borhan, M. A., Bedford

# news notes.

### Here and There

**Dr. Michael Burnley** of Evansville has been certified by the American Board of Emergency Medicine.

**Dr. John E. Joyner**, an Indianapolis neurological surgeon, has been elected board chairman of the National Medical Association.

**Dr. Ray L. Henderson** of Indianapolis has been elected chairman of the National Medical Association's Internal Medicine Section.

**Dr. Harry A. Mahannah**, a Muncie psychiatrist, participated in a panel discussion on "The Role of the Mental Health Expert in Custody Disputes" during a recent seminar in Columbus.

**Dr. Glen A. Brunk**, a Carmel urologist, discussed methods of treating sexual dysfunction during an August meeting of the Hendricks County Hospital Ostomy Club.

**Dr. James A. Crossin** of Indianapolis has been elected president of the Indiana Chapter, American College of Surgeons, for 1984-85; **Dr. Joe G. Jontz** of Fort Wayne is president-elect, and **Dr. Robert E. Lempke** of Columbus is secretary-treasurer.

**Dr. Ara V. Dumanian** of Hammond discussed coronary artery surgery during a July meeting of the Michigan City Mended Hearts Club.

**Dr. Anthony J. Cossell** of Noblesville was guest speaker at the August meeting of the Riverview Hospital Cardiac Club.

Dr. Wallace R. Van Den Bosch, medical director of the Alzheimer's disease detection program at Caylor-Nickel Medical Center, Bluffton, addressed the clinic's newly formed support group in August.

Dr. Franklin D. Wilson, an Indianapolis orthopedic surgeon, led the discus-

**Dr. Franklin D. Wilson**, an Indianapolis orthopedic surgeon, led the discussion during an August sports medicine seminar in Indianapolis.

**Dr. John G. Mathis** and **Dr. Vincent C. Scuzzo** of South Bend addressed a July meeting in South Bend of the Michiana Chapter, National Foundation for Ileitis and Colitis.

**Dr. John E. Gilliland** of Franklin discussed his experiences in Honduras as a member of a traveling medical teaching team during an August meeting of the Franklin Lions Club.

**Dr. Raymond J. Doherty** of Merrillville discussed adolescent alcohol and drug abuse during a July community awareness seminar sponsored by the Alcoholism Institute of The Methodist Hospitals.

**Dr. David S. Batt**, an Indianapolis rheumatologist, discussed arthritis during a July health forum at Anderson College.

**Dr. King S. Jones** of Michigan City received a Distinguished Service Award from his alma mater, Howard University, during the recent annual meeting of the National Medical Association. (He was winner of ISMA's 1981 Physician Community Service Award.)

### Third Generation Doctor

When Dr. Paul Siebenmorgen's daughter became his family practice associate in July, it marked the first time one family has provided three consecutive generations of physicians to Terre Haute.

Dr. Susan Siebenmorgen Amos, a 1981 graduate of the I.U. School of Medicine, joined her father in the practice of family medicine this summer after completing a three-year residency at Terre Haute's Union Hospital.

Her father, Dr. Paul Siebenmorgen, chairman of the ISMA Board of Trustees, entered practice in Terre Haute with his father, the late Dr. Louis Siebenmorgen, in 1946.

Dr. Amos' husband Kenneth is a safety engineer for the Meridian Insurance Co.

**Dr. J. Winston Harper** of East Chicago served as volunteer team physician for the 10 members of the Guyana squad who participated in the 1984 Olympics, held in Los Angeles this summer.

**Dr. Ronald Hamaker** of Indianapolis discussed "Intraoperative Radiation Therapy" at the International Conference on Head and Neck Cancer in Baltimore in July; he also participated in a panel discussion on "Management of the N<sub>3</sub> Neck."

### **Auto Occupant Safety**

The AMA has announced it is pleased that the Dept. of Transportation has issued a final rule concerning automobile occupant protection.

Under this rule, the DoT has decided to require automatic occupant protection systems (such as airbags or passive interiors) in all passenger automobiles, based on a phase-in schedule beginning Sept. 1, 1986. The schedule remains in place unless, before April 1, 1989, two-thirds of the U.S. population is covered by mandatory seat belt use laws that meet specific conditions.

Recently, the AMA reaffirmed its policy that supports mandatory seat belt use laws. It also supports mandated child passenger restraint laws, legislative action to promote availability of effective seat belts in all school buses, and legislative action to promote availability of effective seat belts in all motor vehicles in public use, including such conveyances as buses and taxi cabs.



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### **New ISMA Members**

The following physicians were welcomed in July as new members of the Indiana State Medical Association:

Michael D. Aja, M.D., Indianapolis, therapeutic radiology

Robert B. Bradfield, M.D., Indianapolis, therapeutic radiology

Sue E. Braunlin, M.D., Indianapolis, anesthesiology

David W. Brewer, M.D., Evansville, family practice

Chester R. Burkett, M.D., Poseyville, family practice

Stephen D. Coon, M.D., Indianapolis, therapeutic radiology

Daniel P. DeCamp, M.D., Greenwood, family practice

Donald E. Duggan, M.D., Beech Grove, family practice

Michael W. French, M.D., Indianapolis, neurology

Latif M. Hamed, M.D., Indianapolis, ophthalmology

David A. Heck, M.D., Indianapolis, orthopedic surgery

Marshall E. Hicks, M.D., Indianapolis, radiology

Stephen P. Hollenberg, M.D., Elkhart, obstetrics and gynecology

Verlin T. Houck, M.D., Nappanee, family practice

Richard W. Jackson, M.D., Beech Grove, orthopedic surgery



Douglas Jensen, M.D., Elkhart, otorhinolaryngology

Walter C. Johantgen, Jr., M.D., Indianapolis, anesthesiology

Alan H. Johnson, M.D., Evansville, orthopedic surgery

Erica P. Juergens, M.D., Beech Grove, family practice

Phyllis Martin-Simmerman, M.D., Lafayette, diagnostic radiology

Freeman Miller, M.D., Goshen, orthopedic surgery

Richard O. Oni, M.D., Gary, orthopedic surgery

Stephen G. Pappas, M.D., Indianapolis, neurology

Lana K. Patch, M.D., Beech Grove, family practice

Jack C. Siebe, M.D., Gary, family practice

Brett A. Stephens, M.D., Indianapolis, diagnostic radiology

Stanley D. Strycker, M.D., Milford, family practice

Michael A. Strzelecki, M.D., South Bend, unspecified

Christine Tsolakos, M.D., Plainfield, family practice

James R. VanCuren II, M.D., Goshen, obstetrics and gynecology

Kolala Vasudevamurthy, M.D., Marion, internal medicine

Thomas R. Vidic, M.D., Elkhart, neurology

### 3-Year Accreditation

The CPC Valle Vista Hospital in Greenwood has been granted a three-year accreditation by the Joint Committee on Accreditation of Hospitals. The hospital is devoted to treatment of psychiatric illnesses and chemical dependencies in adults and adolescents.

### White House Fellowships

The application period is now open for the White House Fellowship program, designed to provide gifted and highly motivated Americans with first-hand experience in government and leadership.

U.S. citizens are eligible to apply during the early and formative years of their careers. There are no basic educational requirements and no special career or professional categories. Employees of the federal government are not eligible, with the exception of career military personnel.

During a one-year assignment in Washington, fellows serve as special assistants to Cabinet secretaries or senior members of the White House staff. In addition, they participate in an extensive educational program that includes seminars with top government officials, leading scholars, journalists and private sector leaders.

Application forms and additional information can be obtained from the President's Commission on White House Fellowships, 712 Jackson Place, N.W., Washington, D.C. 20503—(202) 395-4522. Applications must be postmarked no later than Dec. 1, 1984.

### **DRG Physician Guide**

The Greater Cleveland Hospital Association has published Case Approach to DRG Assignment: A Guide for Physicians. The booklet was prepared to assist physicians in understanding and dealing with DRG assignment, and is recommended to ISMA members.

Prices: 1 to 24 books are \$12.50 each plus \$3 postage and handling, 25 to 50 books are \$10 each plus lot shipping charge, 51 books or more are \$9 each plus lot shipping charge. Make check payable

to The Center for Health Affairs, Greater Cleveland Hospital Association, 1226 Huron Road at Playhouse Square, Cleveland, Ohio 44115, Attn: Management Services Division. Phone number is: (216) 696-6900.



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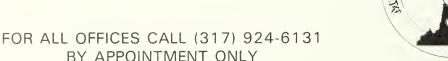
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References: 1. Kales J et al: Clin Pharmacol Ther 12:691-697, Jul-Aug 1971. 2. Kales A et al: Clin Pharmacol Ther 18:356-363, Sep 1975. 3. Kales A et al: Clin Pharmacol Ther 19:576-583, May 1976. 4. Kales A et al: Clin Pharmacol Ther 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: J AM Geriatr Soc 27:541-546, Dec 1979. 6. Kales A, Kales JD: J Clin Pharmacol J. Alden MD, S. 140-150, Apr 1983. 7. Greenblatt DJ, Allen MD, S. Limmerman AM. Curr Ther Res 13:18-22, Jan 1971. 9. Armein R et al: Drugs Exp Clin Res 9(1):85-99, 1983. 10. Mont JM: Methods Find Exp Clin Pharmacol 3:303-326, May 1981. 11. Greenblatt DJ et al: Sleep 5(Suppl 1):S18-S27, 1982. 12. Kales A et al: Pharmacology 26:121-137, 1983.

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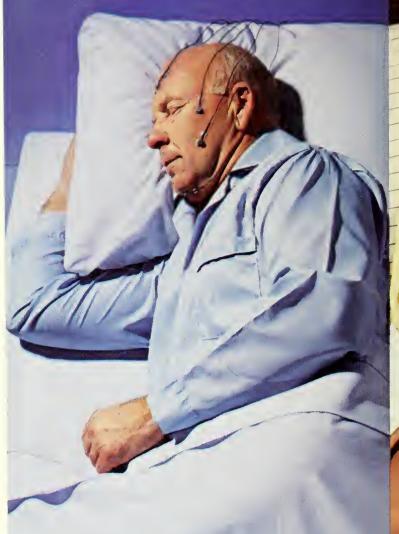
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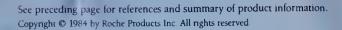
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NOVEMBER 1984

VOL.77

NO.11

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The Journal of the Indiana State Medical Association

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### MUSEUM NOTES

CHARLES A. BONSETT, M.D., Indianapolis



N OPINION SHARED by many Indiana physicians of the time was that expressed by Dr. J. R. Weist in behalf of the Wayne County Medical Society during the 1876 annual meeting of the Indiana State Medical Society:

"Whereas, The ranks of the medical profession are crowded with men having neither natural qualifications, the preliminary education, nor the scientific training to render them proper persons to exercise the privileges, or to assume the responsible duties of the physician; and

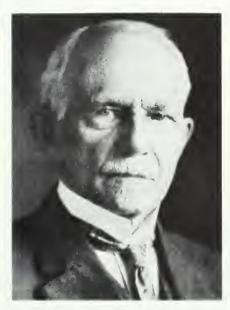
"Whereas, Active competition in a profession composed of such material leads inevitably to depreciation of professional services, and to the practice of arts and trickery to secure business, and to an inability on the part of the public to distinguish between legitimate practice and the quackery of the various medical sects; and

"Whereas, The title of M.D. no longer affords the slightest evidence of either education or respectability on the part of the possessor; and

"Whereas, The evils recited are, to a great degree, the result of a reckless multiplication of medical schools that, by their competition, make the way into the medical profession so broad and easy that the applicant may secure a medical degree almost without price and certainly without the possession of a decent common school education or a knowledge of the most elementary principles of medicine; (therefore, be it)

"Resolved, That the Wayne County Medical Society enter an earnest protest against the multiplication of medical schools in Indiana and that it is the opinion of said society that not more than one medical college in the state should receive recognition from the profession of the state at large, or from the State Medical Society; (and be it further)

"Resolved, That the delegates from this society to the State Medical Society be instructed to present these resolutions to the latter society at its next meeting, and to urge that some proper action be



Dr. Waterman

taken to secure an abatement of the evils complained of."

Indiana had five medical schools at this period and would soon have more, so the problem posed was real. Although the resolution was tabled, it was not without its influence on at least two men in the audience, Dr. Luther D. Waterman and Dr. Thomas B. Harvey, both of whom were founding members of the Indiana Medical College and active members of the teaching staff. Like Dr. Weist, they were aware of the limitations of the proprietary medical school and its numerous problems. Both men attended the first meeting of the Association of American Medical Colleges, held that year (1876) in Philadelphia; the existence of the Association indicated that the problems were not limited to Indiana. Space does not permit the biographies of both men, but a brief account of Dr. Waterman will illustrate the dedication of the men associated with most of these schools. They were concerned with quality in education.

Dr. Waterman, born Nov. 21, 1830 in Wheeling, W. Va., received his undergraduate education from Miami Univer-

sity (Ohio) and his medical degree from the Medical College of Ohio in 1853. He practiced in Kokomo until the outbreak of the Civil War, except for a brief period at Mankato, Minn., where he established the area's first newspaper.

In August 1861, Dr. Waterman was commissioned surgeon of the Thirty-Ninth Regiment, Indiana Volunteers, and served for more than three years. He was captured late in the war and was imprisoned at Macon, Ga. and later at Charleston, S.C.

After the war, Dr. Waterman settled in Indianapolis and practiced medicine and surgery until he retired in 1893. He was elected president of the Indiana State Medical Society in 1877. In 1883 he published a book of verse entitled *Phantoms of Life*. He was interested in many things, particularly education. In 1876, when the Indiana State Medical Society faced a problem in paying for the publication of medical presentations, Dr. Waterman volunteered to cover a third of the cost.

Perhaps Dr. Waterman's greatest single contribution to education came toward the end of his life when he donated properties worth more than \$100,000 to Indiana University to establish an institute for scientific research. This was the largest gift ever received by 1.U. at Bloomington up to that time (1916) and was exceeded only by the Robert Long bequest at the Medical Center a few years earlier.

Dr. Waterman died June 30, 1918, at the age of 87. His services to the Indiana Medical College, the Indiana State Medical Society, the Association of American Medical Colleges, and Indiana University (which ultimately incorporated his medical school into Indiana University School of Medicine) characterize a life of dedication to society.

In eulogizing Dr. Waterman to the 1915 1.U. graduates, Dr. William Lowe Bryan cited two lines from Waterman himself:

"He who would make his life a precious thing/Must nurse a kindly purpose in his soul."

### WHAT'S NEW?

Acuson has introduced a major advance in diagnostic imaging. The new technology, called Computed Sonography<sup>TM</sup>, enables the Acuson 128 system to form ultrasound images electronically—producing images of softtissue structures inside the human body that are two to four times clearer than those made by previously available technology, with all structures in focus throughout the field of view. Further information is available by writing or phoning Sharon Freitas, Acuson, 1393 Shorebird Way, Mountain View, Calif. 94043—(415) 969-9112.

Ives Laboratories reports FDA approval for a new 40 mg. Isordil® Titradose® (Isosorbide dinitrate) for the treatment and prevention of angina pectoris. The development of the higher dosage strength is in response to widespread medical evidence indicating that treatment of angina pectoris requires adequate titration of dosage to obtain optimal patient response.

Schering announces that PRO-VENTIL® (albuterol) Inhaler may now be used for prevention of exercise-induced bronchospasm. Two puffs of albuterol aerosol taken approximately 15 minutes before exercise prevents the bronchospasm caused by physical stress in EIB patients. Albuterol now becomes the only bronchodilator currently indicated for the prevention of exercise-induced bronchospasm as well as for the treatment of all forms of bronchospasm.



"There's still nothing wrong with you, and I'm still not going to invest in your new firm."

News of what is new in the medical supply industry is composed of abstracts from news releases by book publishers and manufacturers of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by INDIANA MEDICINE or by the Indiana State Medical Association.

Hoechst-Roussel will market a new drug, Trental® (pentoxifylline), the first drug proven effective for the treatment of intermittent claudication. It has been available in more than 50 countries since 1972 and may now be sold in the United States. It is effective because it produces red cell flexibility and lowers blood viscosity, thereby permitting blood to flow more freely through arteries narrowed by arterial disease.

KinetiX has a new, portable monitor, designed to provide physicians with early warning of pulmonary incapability. Called the PULMOMETER<sup>TM</sup>, the lightweight, hand-held instrument measures and provides direct digital read outs of forced vital capacities (FVC), forced expiratory volume in first second (FEV-1) and maximum voluntary ventilation (MVV). It has a volume accuracy of 10% plus or minus, and has a range of 2.5 to 5.5 liters.

Merck Sharp & Dohme has received FDA approval for marketing the first suppository form of a prescription nonsteroidal anti-inflammatory drug for treatment of certain forms of arthritis. Suppositories Indocin® (indomethacin, MSD) is particularly suited as an alternate dosage form for patients who cannot or will not take oral medication. The suppository formulation provides a more rapid rate of absorption than capsules and is useful for nightime use for night pain and morning stiffness associated with rheumatoid arthritis and osteoarthritis.

**Mead Johnson** announces introduction of Estrace (estradiol) Vaginal Cream. The cream, along with Estrace tablets, provides a choice of replacement estrogen products.

Norwich Eaton is maintaining a case study of malignant hyperthermia and invites physicians to report any incidents of MH. Norwich Eaton is the maker of Dantrium, which is the drug, when used vigorously by intravenous route early in the onset of malignant hyperthermia, that offers the only hope of cure. Norwich Eaton publishes "Malignant Hyperthermia Alert" to record case reports and discuss treatment, and to stress the necessity of maintaining an adequate stock of both intravenous and oral preparations of Dantrium.

Schering is introducing NORM-ODYNE® (labetalol HCl), a new antihypertensive with a unique dual mechanism of action. Normodyne functions as an alpha and beta blocker and as a vasodilator. The clinical research indicates that side effects of the new agent are less frequent as compared with other antihypertensives. It will lower blood pressure safely and promptly within one to two hours when given orally, and within minutes when used intravenously to treat hypertensive emergencies.

General Electric has a variable air support mattress to provide patient comfort and support. Named the RAD-PAD<sup>TM</sup>, it causes less image magnification and attenuates less radiation than thick foam pads. It is self-inflating. Maximum patient comfort may be obtained by releasing small quantities of air. It is available in four sizes. It is waterproof, stain resistant and easy to clean.



"It's \$20 for an office visit, plus \$25 for an annual leatherette album with a copy of your medical records."

### THE CONSEQUENCES CAN BE LIFE-SHORTENING.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease...diabetes...hypertension... congestive heart failure...an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight—if, in fact, it is ever achieved.

### **The Institute for Health Maintenance** (IHM) can help.

Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss:

THE RISK FACTOR **OBESITY PROGRAM** (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised sup-

plemented fast with long-term behavioral and nutritional training.

Under the supervision of the IHM medical staff, patients lose weight safely and consistently over a period of weeks and months. They receive their total daily nutritional requirements from a low-calorie egg albumen formulation and a multivitamin tablet... a supplement they stay with until goal weight is achieved.

### The success of the RFO Program has been significant.

Over the past five years, thousands of patients have lost from 25 to over 100 pounds, with the average loss being 63 pounds. More important, 75%\* of these patients have been able to sustain their new low weight levels with the help of our 18-month maintenance program.

Some have called the RFO Program "lifesaving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors-



one we at IHM can help control.

To learn more about us and how this program can safely benefit some of your patients, please contact one of our medical directors at a clinic near you.

\*Data on file, Institute for Health Maintenance.

### The Risk Factor Obesity Program

Medically designed, Medically supervised, Medically sound.

Institute Maintenance

A division of National Medical Care, Inc.

Indianapolis (317) 872-8013

### FUTURE FILE.

### Indiana University CME

For the Primary Care Physician

Nov. 28—OB/GYN Symposium, Indianapolis.

Clinical Syndromes of Altered Immunity, Reid Memorial Hospital, Richmond.

### For the Specialist

Nov. 16—Evoked Potentials Seminar, I.U. Medical Center campus.

Nov. 30-Dec. 1—American College of Physicians Regional Meeting.

For additional information, contact the CME Division, Indiana University School of Medicine—(317) 264-8353.

### Residents Fair, Workshop

A Practice Opportunity Fair for resident physicians and physicians seeking to expand their practice will be conducted Friday, Nov. 30, from 3-7 p.m. in the conference rooms of St. Vincent Hospital Professional Building, Indianapolis.

Displays and tables set up by hospital administrators and communities seeking physicians will be included in the fair, which is sponsored by the ISMA Resident Medical Society. To reserve table space, please contact ISMA Headquarters.

The AMA's **Starting Your Practice Workshop**, sponsored by the ISMA and its Resident Medical Society, will be conducted Nov. 30 and Dec. 1 at St. Vincent Hospital, Indianapolis. Residents and other physicians entering private practice are urged to attend. For further information, contact ISMA Headquarters.

### Two Utah CME Meetings

The Scott and White Clinic and the Texas A&M University College of Medicine will conduct two CME meetings in Utah this winter.

"Clinical Topics in Internal Medicine" will be the subject at Snowbird Resort, Snowbird, Utah, Feb. 2-9. "Clinical Topics in Gynecologic Endocrinology for the Primary Care Physician" will be the subject at Prospector Square Resort, Park City, Utah, March 9-16.

Contact Office of CME, Scott and White, Temple, Texas 76508—(817) 774-2350.

### Rheumatology Fellowship

A mini-fellowship in rheumatology is being offered by the Rheumatology Division, Dept. of Medicine, Indiana University School of Medicine.

The 40-hour instructional program, designed for general internists, family physicians and general practitioners, will be conducted at the I.U. Medical Center for five consecutive days, or under other suitable arrangements.

This program should assist the participant in attaining the skills for effective office management of common rheumatologic problems, interpretation of relevant laboratory tests, and techniques for joint aspiration and local soft tissue injection. This will include experience with the "team approach" to management of the arthritic patient.

Contact the CME Division, I.U.S.M., 1120 South Drive, Indianapolis 46223—(317) 264-8353.

### CME Calendar

CME meetings announced by the Methodist Hospital of Indiana are as follows:

Nov. 30 & Dec. 1—"Cataract Surgery Seminar and Basic Technique Update," at Radisson Plaza Hotel, Indianapolis.

Nov. 28—Third Annual Symposium on Ethical and Moral Issues: "Health Care of the Poor—Who Pays—Am I My Brother's Keeper?", Adam's Mark Hotel, Indianapolis.

Dec. 5—"Hemodynamic Monitoring: State of the Art," at Methodist Hospital, Indianapolis.

Further information is available from Dixie Mattingly, CME Coordinator, Methodist Hospital, 1604 N. Capitol Ave., Indianapolis 46202—(317) 929-3733.

The Journal of the American Medical Association publishes a list of CME courses for the United States twice yearly. The January listing features courses offered from March through August; the July listing features courses offered from September through February.

### Diagnostic Imaging

"Diagnostic Imaging—CT, MRI and Ultrasound" will be the subject of a post-graduate seminar conducted by the Dept. of Radiology, University of Texas Health Science Center in Dallas, Feb. 4-9, at Montego Bay, Jamaica.

The course carries 20 credits, AMA Category 1. The fee is \$350 for physicians, \$200 for residents and fellows.

Contact Dolley Christensen, 5323 Harry Hines Bldg., Dallas, Tex. 75235— (214) 688-2502 or 688-2166.

### Counselor Workshop

The Menninger Foundation will conduct an advanced workshop Feb. 4-5 for clergy and pastoral counselors. The subject matter is especially adapted for chaplains serving in mental health settings. Tuition is \$175.

For information, contact Richard A. Bollinger, DMin, The Menninger Foundation, Box 829, Topeka, Kan. 66601—(913) 273-7500, ext. 5818.

### Immunology and Cancer

"Immunology and Cancer" is the title of the 38th annual Symposium on Fundamental Cancer Research, which will meet Feb. 26 to March 1 at the Shamrock Hilton Hotel, Houston.

For details, contact Office of Conference Services, Box 131, M. D. Anderson Hospital and Tumor Institute, 6723 Bertner Ave., Houston, Tex. 77030—(713) 792-2222.

### Reconstructive Microsurgery

The American Society for Reconstructive Microsurgery will attend an inaugural meeting Jan. 18-19, immediately preceding the annual meeting of the American Society for Surgery of the Hand. The M.G.M. Grand Hotel in Las Vegas will host both meetings. Reconstructive Microsurgery will be the subject of the program.

Registration fees are \$350 for active members and guests, \$200 for associate and corresponding members, and \$200 for training residents. Telephone: (212) 920-5551.

### Ski Conference

The sixth annual Mammoth Mountain Emergency Medicine Ski Conference will be held March 10-15 at Mammoth Lakes. Calif.

Fees are \$325 for physicians, \$190 for nurses, and \$225 for physicians in training and physician's assistants. The program is accredited for 20 hours, Category

Contact Daniel L. Abbott, M.D., Medical Conferences, P.O. Box 52-B, Newport Beach, Calif. 92662—(714) 650-4156.

### **Pediatric Brain Insults**

"Brain Insults in Infants and Children: Pathology, Evaluation, Diagnosis and Acute Management" is the title of a CME conference to be held March 7-9 at the Holiday Inn at the Embarcadero, San Diego. AMA/CMA credit is 17 hours.

Contact Office of CME, MO17 UC San Diego School of Medicine, La Jolla, Calif. 92093—(619) 452-3940.

### Internal Medicine

ISMA members are invited to attend a CME meeting on "The Year in Internal Medicine," to be held Jan. 23-26 at the Alumni Center for CME, Northwestern University Medical School, 301 E. Chicago Ave., Chicago 60611.

CME accreditation is 22 hours, Category 1. The fee is \$205. Telephone: (312) 649-8533.



### Clinical Cytopathology

The Johns Hopkins University School of Medicine will offer two postgraduate courses in clinical cytopathology next year. They are solely for pathologists.

For credit, both courses must be taken: March to May 1985, Home Study Course A is provided each registrant for intensive personal study; and from May 6-17 In-Residence Course B will be conducted at the Johns Hopkins Medical Institutions, Baltimore. Upon successful completion, 152 AMA Category 1 credit hours will be awarded.

For details, write John K. Frost, M.D., 604 Pathology Bldg., The Johns Hopkins Hospital, Baltimore, Md. 21205.

### Internal Medicine Update

ISMA members are invited to attend a two-day scientific meeting of the American College of Physicians, which will be held Friday and Saturday, Nov. 30 and Dec. 1. The program will be devoted to updating medical knowledge in the field of internal medicine. The fee for non-members is \$10.

For information and reservations contact Dr. Richard C. Powell, I.U. Medical Center, 1100 W. Michigan St., Indianapolis 46207—(317) 264-8684.

### **Nutrition Meeting**

The American Society for Parenteral and Enteral Nutrition will conduct its 9th Clinical Congress Jan. 21 to 24 at the Fontainbleau Hotel, Miami Beach, Fla.

For details write or phone A.S.P.E.N., 1025 Vermont Avenue, NW, Suite 810, Washington, D.C. 20005—(202) 638-5881.

### Dementia in the Elderly

"Recent Advances in Geriatric Medicine: Dementia in the Elderly" is the subject of a CME course to be conducted Jan. 31-Feb. 2 by the University of California at San Diego School of Medicine at the Holiday Inn at the Embarcadero in San

The fee is \$210 for physicians, \$140 for allied health professionals, residents and students.

For details, contact the Office of CME, UC San Diego School of Medicine, M-17, La Jolla, Calif. 92093-(619) 452-3940.

### **Neurology Conference**

"Neurology for the Non-Neurologist" is the subject of a CME conference Dec. 12 to 14 at the Westin Hotel, Chicago. It is sponsored by the Rush-Presbyterian-St. Luke's Medical Center.

For information, contact the medical center at 600 S. Paulina, Chicago 60612—(312) 942-7095.

### Florida Symposium

"Ear, Nose and Throat Diseases in Children" will be the subject of a fiveday symposium to be presented Dec. 5-9 at The Breakers in Palm Beach by the Depts. of Otolaryngology and Pediatrics of the University of Pittsburgh School of Medicine.

The course offers 17 CME credit hours. Tuition is \$250 for physicians, \$185 for residents.

Contact the Dept. of Otolaryngology, Children's Hospital of Pittsburgh, 125 De Soto St., Pittsburgh, Pa. 15213—(412) 647-5466.

### **Heart Disease**

"New Approaches to the Management of Profound Congestive Heart Failure" will be the subject of the 4th Annual Conference on Heart Disease by the University of Wisconsin Medical School at the Westowner Hotel, Madison, Dec. 7 and 8.

Full information is available from Sarah Aslakson, 465B WARF Bldg., 610 Walnut Madison, Wisc. 53705-St., (608) 263-2856.



already told my broker to sell.'

### WILLIAM M. DUGAN, JR., M.D.

Clinical Oncology Center Methodist Hospital of Indiana, Inc. New information from Indiana Division American Cancer Society, Inc. 4755 Kingsway Dr., Suite 100 Indianapolis 46205

EVERY PHYSICIAN'S OFFICE— A CANCER DETECTION CENTER

### CANCER CORNER

#### Nutrition and Cancer

An ACS special report, "Nutrition and Cancer: Cause and Prevention," was published in *Ca* in February. That report is now available as a professional education publication (Code #3389).

According to the report, there is "good reason to suspect that dietary habits contribute to human cancer." The interpretation of data is very complex and, as yet, does not allow clear-cut conclusions. Associations between dietary practices and certain cancers do not necessarily imply causation. Nonetheless, the society believes there is enough inferential information to make a series of interim nutritional recommendations that are likely to provide some measure of reducing cancer risk.

Substances that have received much attention, such as coffee and artificial sweeteners, are reviewed, but no specific recommendations are made at this time because of insufficient data. The report also includes a description of the methods used to investigate the role of the diet in the development of cancer.

#### More on Nutrition

Following its report on nutrition and cancer in February 1984, the American Cancer Society has published "Nutrition, Common Sense and Cancer."

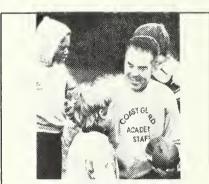
According to the quick-reference leaflet, evidence indicates that eating certain foods may increase or decrease one's risk of developing certain cancers, although no direct cause-effect relationship between diet and cancer has yet been proven.

Briefly explained are the ACS's seven nutritional guidelines:

- · Avoid obesity.
- Cut down on total fat intake.
- Eat more high-fiber foods.
- Include foods rich in vitamins A and C in your daily diet.
- Include cruciferous vegetables in your diet.
- Eat moderately of salt-cured, smoked and nitrite-cured foods.

• Keep alcohol consumption moderate, if you do drink.

"Nutrition, Common Sense and Cancer" notes that the development of cancer involves many complex factors, and states that research on the links between nutrition and cancer is being funded by the American Cancer Society.



### OTTO GRAHAM HAS MADE A COMEBACK.

Otto Graham, one of football's greatest quarter-backs, has made a successful come-back: from colorectal cancer. He and almost 2 million others are living proof your contributions count.

### CANCER CAN BE BEAT.

#### **ACS Factbook**

The 1984 revised edition of the ACS "Factbook for the Medical and Related Professions" (Code #3076) is now available. It replaces the 1980 version.

The factbook, written as an introduction to the ACS for health professionals, describes the society's organizational and financial structure, as well as its services and programs.

### Nabilone Dosage Correction

It has been brought to our attention that there is an error in the drug dosage on page 5 of the article, "The Problem of Nausea and Vomiting in Modern Cancer Chemotherapy," by John R. Durant, M.D., in the January/February 1984 issue of *Ca*.

According to Eli Lilly and Company, sole manufacturer of nabilone in this country, the normal dosage is one to two milligrams once or twice a day. Eli Lilly has told *Ca* that nabilone is not currently commercially available in the United States, but it is being used in controlled clinical trials here. Nabilone has been approved for use in other countries and *is* commercially available in Canada and the United Kingdom; Eli Lilly has alerted its affiliates in those two countries so that they may, in turn, alert physicians.

### Salivary Gland Tumors

"Tumors of the Major and Minor Salivary Glands" (Code #3383) is a new professional education publication prepared by Dr. Robert J. McKenna, University of Southern California School of Medicine in Los Angeles.

Tumors of the major and minor salivary glands, both benign and malignant, represent about 6% of all head and neck tumors. Dr. McKenna analyzes these tumors as a group, which is rarely done in the literature, although such tumors do have similar morphologic and clinical patterns.

Dr. McKenna reviews their causes, location and incidence, clinical presentation and diagnosis, treatment, pathology, and trends in survival. Fourteen tables and 14 color photographs depicting salivary gland pathology are included.

### 'Cancer Statistics, 1984'

The 1984 edition of the ACS's yearly publication on cancer statistics (Code #3033) is now available.

This pamphlet presents 18 tables and figures with extensive statistical data on cancer incidence, mortality and survival.

## Motrin reduces inflammation, pain ...and price

### New low price...major savings

The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom Motrin Tablets are prescribed.

### Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with Motrin Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

Please turn the page for a brief summary of prescribing information.



Good medicine...good value

Motrin" Tablets (ibuprofen)

Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, judides, or other nonsteroidal anti-inflammatory agents

**Warnings:** Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets **Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets, use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done

Motrin Tablets can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, skin rash, weight gain, or edema

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

**Drug interactions.** Aspirin used concomitantly may decrease Motrin blood levels Cournarin bleeding has been reported in patients taking Motrin and cournarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers

**Adverse Reactions:** The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea\* epigastric pain\* heartburn\* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence): Central Nervous System: Dizziness\* headache, nervousness: Dermatologic: Rash\* (including maculopapular type), pruritus, Special Senses: Tinnitus; Metabolic/Endocrine: Decreased appetite, Cardiovascular: Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS)

Incidence less than 1%-Probable Causal Relationship\*\*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests, Central Nervous System: Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia, Special Senses: Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAU-TIONS); Hematologic: Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit, Cardiovascular: Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations, Allergic: Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); Renal: Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria, Miscellaneous: Dryeyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causat Relationship Unknown\*\*

Gastrointestinal: Pancreatitis; Central Nervous System: Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri, Dermatologic: Toxic epidermal necrolysis, photoallergic skin reactions, Special Senses: Conjunctivitis, diplopia, optic neuritis; Hematologic: Bleeding episodes (e.g., epistaxis, menorrhagia), Metabolic/Endocrine: Gynecomastia, hypoglycemic reaction, Cardiovascular: Arrhythmias (sinus tachycardia, sinus bradycardia), Allergic: Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; Renal: Renal papillary necrosis.

\*Reactions occurring in 3% to 9% of patients treated with *Motrin* (Those reactions occurring in less than 3% of the patients are unmarked.)

\*\*Reactions are classified under "Probable Causal Relationship (PCR)" if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under "Causal Relationship Unknown" if seven or more events have been reported but the criteria for PCR have not been met.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis Suggested dosage is 300, 400, or 600 mg t i.d. or q i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription

MED B-7-S

Motrin is a registered trademark of The Upjohn Manufacturing Company

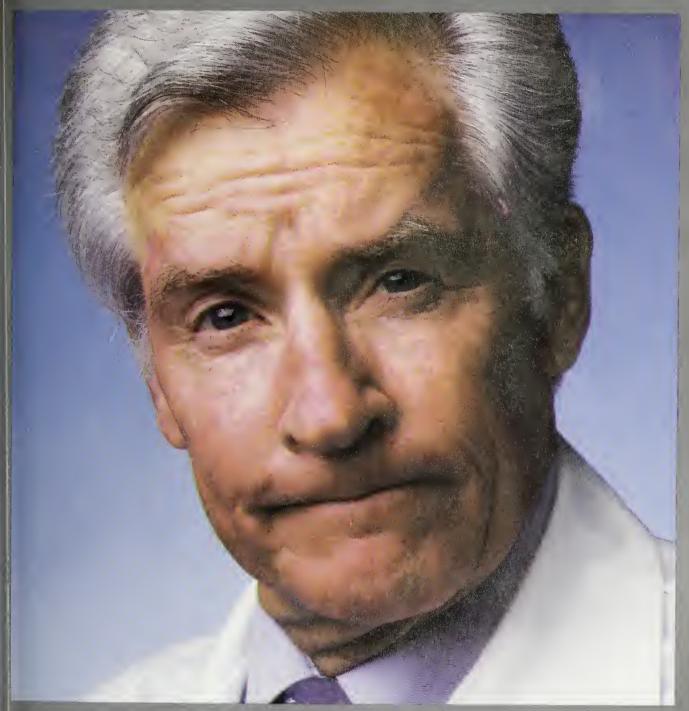


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### T. S. DANIELSON, JR., M.D., M.P.H. Acting State Health Commissioner

New information from Office of the Commissioner Indiana State Board of Health 1330 W. Michigan St. Indianapolis, Ind. 46206 317-633-8400

### PUBLIC HEALTH NOTES.

Farlier this year. Hoosiers heard a great deal about the hazards of drinking raw, unpasteurized milk following allegations of irregularities in the state's dairy cattle industry. Since then, several events in other parts of the country make it worth noting that the consumption of raw milk is a public health risk that is not worth taking.

The situation nationwide has escalated to the point that the U.S. Food and Drug Administration held informal public hearings in mid-October in Washington, D.C., on whether there is a need to require—on a national level—the pasteurization of milk and milk products sold for human consumption.

Sixteen cases of gastroenteritis at a western Kentucky convent from March 28 to May 2, 1984, were attributed by the Centers for Disease Control (CDC) to be the likely result of consuming inadequately pasteurized milk purchased from a nearby ray milk dealer.

The Minnesota Department of Health reported in July that more than 50 patients in Braincrd had experienced chronic darrhea of more than four weeks duration, and that the consumption of raw milk from a single dairy was the only significantly associated risk factor in the 50 cases. In fact, the situation in Minnesota was so severe that even two months after these patients stopped drinking raw milk, many of them continued to report 10-20 diarrheal episodes daily, and none of the patients reported having fully recovered. The Minnesota Department of Health reported that metronidazole, erythromycin, and tetracycline therapy were not successful in reducing or eliminating the diarrhea.

California, where the nation's largest retailer of raw milk (Alta-Dena) is located, reports that Salmonella dublin incidence is increasing and is increasingly associated with the drinking of raw milk. California health officials say that since 1980, 16 deaths have occurred in people with Salmonella dublin infections who drank raw milk—seven deaths occurred in 1983 alone. The CDC says that the risk of contracting S. dublin from raw milk in

California last year was estimated at 458.3 per million population, contrasted with a rate of 2.9 per million for S. dublin patients who did not drink raw milk.

The CDC said further that "the association between raw milk ingestion and S. dublin disease in California in 1983 was about 15 times stronger than the well accepted association between cigarette smoking and lung cancer." The CDC concluded that "salmonellosis from raw milk is a potential hazard that merits greater appreciation by consumers, producers, and health care providers."

### A Mistaken Impression

Consumers who drink raw milk because they are under the mistaken impression that it is somehow more natural, and thus healthier for them, should know that such a rationale is not true.

State law requires that all milk sold commercially in Indiana be pasteurized. This assures the consumers that the milk purchased at the local grocery or convenience store is safe to drink.

In spite of the law requiring pasteurization, some farmers, and even health food stores, have been known to sell raw milk. It is believed that a great deal of raw milk—from cows as well as goats—is sold in "underground" markets in Indiana. It appears that the consumption of raw milk has increased in recent years, perhaps for two reasons: (1) it is increasingly popular to consume "natural" food products, and (2) in relatively tough economic times, there is an incentive for some farm families to attempt to increase their income by selling raw milk to their friends and neighbors.

Pasteurization is the heat treatment of milk which kills any disease-causing organisms that may be present in the milk. Without question, raw milk offers the public much less protection from disease than does pasteurized milk.

Prior to the insistence by public health regulatory agencies that milk be pasteurized, numerous documented cases of typhoid fever, septic sore throat, dysentery and diphtheria were regularly attributed to the consumption of raw milk. Nowadays, common diseases associated with the consumption of raw milk include salmonellosis, campylobacteriosis. Q fever, mycobacterial disease, staphylococosis, streptococcosis, streptobacillosis, toxoplasmosis, and brucellosis.

Health food advocates claim that pasteurization destroys the nutritional value of raw milk, but a closer examination of their claims shows that while vitamins C and B are reduced by approximately 10%, the practical effect of this is minimal.

### Brucellosis in Humans

Brucellosis is a very special disease that can be contracted by drinking raw milk—it is particularly special in that it can present problems in being diagnosed.

The time between exposure to brucellosis in cattle and the resulting development of symptoms in a human may vary from a few days to several months, and thus origins of infection may go unrecognized. The symptoms of brucellosis are characteristic of many disorders, including emotional disturbances.

Those symptoms include continued, intermittent, or irregular fever of variable duration, headache, weakness, profuse sweating, chills, depression, and generalized aching. The disease may last for several days, months, or occasionally several years. The fatality rate without treatment is 2% or less; recovery is usual but resulting disability is often pronounced. Part or all of the original syndrome may reappear as relapses.

Approximately 170 cases of brucellosis in humans are reported each year in the U.S.—by contrast, there were 6,400 cases reported in 1947. No cases were reported in Indiana in 1983 or thus far in 1984. There is no evidence that it can be transmitted from one human to another.

Of particular concern from a public health standpoint is that young doctors—who may have never seen a patient with brucellosis—may misdiagnose the illness as influenza or some other common infection. Physicians who are aware that their patient has been in contact with infected animals or raw milk should have little trouble immediately diagnosing brucellosis.

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### **Sexually Transmitted Diseases**

ROBERT B. JONES, M.D. Indianapolis

The author is Associate Professor of Medicine and Associate Professor of Microbiology and Immunology, Indiana University School of Medicine.

Correspondence: Indiana University School of Medicine, Dept. of Medicine, Div. of Infectious Diseases, Emerson Hall 302, 545 Barnhill Drive, Indianapolis, Ind. 46223.

T IS ESTIMATED that between 5 and 10 million Americans acquire a new sexually transmitted disease each year.

Figure 1 shows the number of cases of gonorrhea reported annually to the Centers for Disease Control since 1940. The exponential increase beginning in 1965 coincided with the introduction and widespread acceptance of oral contraceptives. Since 1975 there has been a slight decline in the annual incidence of gonorrhea. This has been attributed to an aggressive control program instituted in 1972, and to a lesser extent, to changes in sexual mores. Several of the other sexually transmitted diseases listed in Table 1 have increased in incidence during the same period, and several continue to do

#### **Chlamydial Infections**

C. trachomatis is an obligate intracellular parasite which is the cause of lymphogranuloma venereum (LGV) and a variety of ocular, genital, and respiratory syndromes.<sup>2</sup> LGV usually presents

with a painful inguinal lymphadenopathy in association with malaise, chills, fever, and occasionally meningitis. The involved nodes may become fluctuant and break down and drain spontaneously if not aspirated. LGV can also present as a severe proctitis, which clinically and pathologically resembles Crohn's disease, and with which it is easily confused.<sup>3</sup>

Non-LGV strains of *C. trachomatis* cause nongonococcal urethritis (NGU), acute epididymitis, and probably some cases of chronic prostatitis in men. The management of a man with urethritis is presented in *Table 2*. Although men most frequently present with symptoms indicative of a chlamydial infection, women are far more likely to suffer significant morbidity from such infections.

Most women with chlamydial urethritis or cervicitis are asymptomatic. However, about one-third of women with the "urethral syndrome" have chlamydial urethritis; the remaining two-thirds have a low-grade bacterial cystitis. This syndrome is defined as dysuria, frequency,

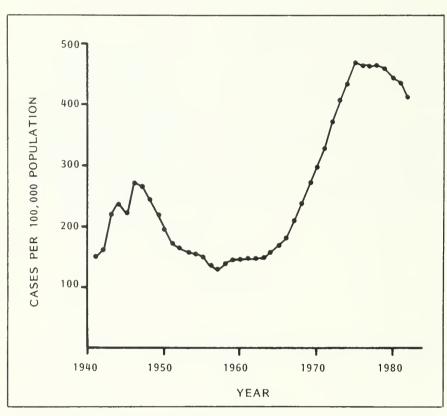


FIGURE 1: Civilian cases of gonorrhea by year reported to the Centers for Disease Control. Adapted from reference 1.

and pyuria in the absence of significant bacteriuria.<sup>3</sup> Similarly, the cervix appears normal in many women with endocervical infection, while others have signs of cervicitis, including a mucopurulent endocervical discharge, friability, and/or ectopy with erythema and edema.

The frequency with which chlamydia ascends the genital tract to produce endometritis and/or salpingitis is unknown. However, salpingitis is the major complication of chlamydial infections in women. Unfortunately, it is frequently subclinical, and only discovered as part of an evaluation for infertility. There is a strong association between tubal disease as a cause of infertility and serological evidence of past or current chlamydial infection.4 Also, we have recently isolated chlamydia from the tubes of several women who were undergoing microtuboplasty to correct tubal infertility, but had no history of clinical salpingitis.

Even when it is clinically apparent,

chlamydial salpingitis tends to follow a subacute, or chronic, course with the duration of pain often exceeding 10 days before the patient seeks medical attention.6 In contrast, gonococcal salpingitis tends to be a relatively acute disease with severe abdominal pain, fever, and an elevated peripheral white blood cell count. Women with non-gonococcal, non-chlamydial, salpingitis frequently have had prior episodes of salpingitis, and also tend to present acutely. They are far more likely to present with an abscess, and to be infected with anaerobes and Gram negative aerobes, which are part of the normal vaginal flora.

As many as 50% of women with uncomplicated gonorrhea, and 20% with gonococcal salpingitis, are co-infected with chlamydia. If these women are treated with antibiotics active against gonorrhea, but not against chlamydia (e.g., ampicillin), many will later develop either clinical or subclinical chlamydial

salpingitis. Consequently, an agent active against chlamydia should be included in the treatment of gonorrhea. In a patient likely to take medications reliably, this can be a tetracycline alone. One judged less reliable should be treated with an agent effective in a single dose against gonorrhea (e.g., penicillin or ampicillin) followed by a seven-day course of a tetracycline or erythromycin for the chlamydia (*Table 3*).

Chlamydial infections can also be acquired by a neonate during passage through an infected birth canal. Between 30% and 50% of infants born to infected women will develop chlamydial inclusion conjunctivitis, and 10% to 20% will develop chlamydial pneumonia. Both parents of an infected infant should be treated since they are likely to be infected themselves.

Chlamydia are obligate intracellular parasites and can only be grown in tissue culture. However, the sensitivity of culture is probably no better than 80% under optimal conditions, and substantially less in laboratories that are either relatively inexperienced or do not employ optimal techniques. However, false positive cultures are rare, and culture is currently the diagnostic method of choice.

Serological tests may also be of value. A negative microimmunofluorescent (or other comparable) test result indicates that the patient is very unlikely to have a chlamydia infection, unless it has just been acquired. On the other hand, a positive serological test indicates exposure, but cannot distinguish recent from remote infection. Immunofluorescent staining of a genital tract smear (Microtrak, Syva Co.), appears to have a sensitivity and specificity roughly comparable to that of culture, and may prove to be extremely valuable for screening, especially when used in conjunction with a serological test.

However, diagnosis of chlamydial infections in adults frequently depends on clinical criteria. Approximately one-third of women who are sexual contacts of men with NGU are infected with *C. trachomatis*. They should be evaluated clinically for the presence of salpingitis

and then treated empirically regardless of culture results (if salpingitis is present, see pelvic inflammatory treatment regimen in Table 3). However, chlamydia can remain latent for long periods of time, and a newly diagnosed chlamydial infection does not always indicate a new sexual contact. For example, the mother of an infant with chlamydial conjunctivitis may have been carrying the organism in her cervix for a period of several years.

#### Gonorrhea

Men with newly acquired gonococcal infection usually present with complaints of dysuria and a urethral discharge about three to five days after a new sexual contact. In the majority of such men the diagnosis can be made by Gram stain of a urethral smear. Management is as outlined in Table 2. Their female partners should be evaluated for the presence of salpingitis, cultured for N. gonorrhoeae, and then treated without waiting for culture results;9 again, see pelvic inflammatory treatment regimen in Table 3 if salpingitis is present. A female sexual contact of a man with gonococcal urethritis has a 60% to 80% chance of being infected, and 80% of women with untreated gonococcal infection will go on to develop salpingitis. Approximately 10% of infected women will have falsely negative cultures. Cultures are obtained before therapy because those from whom organisms are isolated should have cultures repeated after therapy to insure that treatment has been effective.9

Many women with gonorrhea are symptomatic, although the symptoms are often non-specific. Common complaints include dysuria, dysmenorrhea, mild abdominal pain and vaginal discharge, and women presenting with such symptoms should be evaluated for the presence of gonococcal infection, regardless of social or marital status.

Recommended treatment regimens are about 90%-95% effective. However, multiple drug resistant strains of N. gonorrhoeae have been imported into the United States from the Far East. These strains produce a beta-lactamase, and are not sensitive to penicillin or ampicillin.

### TABLE 1 Common Sexually Transmitted Pathogens

<u>Organism</u>	Associated Diseases
Chlamydia trachomati	Urethritis cervicitis salpingitis perihepatitis epididymitis, proctitis*, inclusion conjunctivitis infant pneumonia, endocarditis lymphogran uloma, venereum, 2 adult atypical pneumonia 2 prostatitis
Neisseria gunorrhoeae	Urethritis cervicitis, salpingitis, epididymitis arthritis dermatitis syndrome, perihepatitis proctitis*, conjunctivitis, endocarditis
Herpes Simplex Virus	Genital ulcers, regional lymphadenopathy proctitis*, urethritis, aseptic meningitis, urinary retention, transverse myelitis, neonatal infection, 2 cervical carcinoma, 2 carcinoma of the vulva
Papilloma viruses	Condyloma acuminata (genital warts), ? probable cervical carcinoma
Hepatitis A and B Viruses	Hepatitis
Treponema pallidum*	Syphilis
Trichomonas vaginalis	Vaginitis
Mycoplasma hominis	Postpartum fever, ? salpingitis
Ureaplasma urealyticum	Urethritis. ? spontaneous abortion
Giardia lamblia*	Giardiasis
Entameoba histolytica*	Amebiasis
? Human T-cell leukemia virus. Type III*	Acquired immunodeficiency syndrome (AIDS)

<sup>\*</sup>Primarily in male homosexuals.

### TABLE 2 Management of a Man with Urethritis Gram Stain

Grain Gtain				
PMN No GNID	PMN ? GNID	PMN GNID		
Culture GC     Treat with regimen effective against nongonococcal ureth-	Culture GC     Treat with regimen effective in both gonococal and non-	Culture optional     Treat with regimen effective in both gonococcal and non-		

gonococcal urethritis Culture

GC Positive

1) Evaluate and treat sexual contacts for chlamydial infection

Negative

1) Evaluate and treat contacts for GC

2) Test of cure culture 3-7 days after treatment completed

Abbreviations PMN = Polymorphonuclear leukocytes GNID = Gram-negative intracellular diplococci GC = gonorrhea

gonococcal urethritis

### TABLE 3 Recommended Treatment for Common Sexually Transmitted Diseases

Known or suspected chlamydial infections, including nongonococcal urethritis, cervicitis, and women who are contacts of men with nonogonococcal urethritis

Uncomplicated gonococcal infections or asymptomatic sexual contact of patients with gonorrhea

Pelvic Inflammatory Disease (SalpingItis)

Genital herpes

Vaginitis Candida sp

Trichomonas vaginalis

Nonspecific ? Gardnerella vaginalis vaginitis

Tetracycline 500mg PO, OID. or doxycycline 100mg BID for at least 7 days Alternative is erythromycin 500mg PO, OID

Tetracycline 500mg PO, OID or doxycycline 100mg PO, BID for 7 days, or aqueous procaine penicillin G. 4 8 million units IM, or ampicillin. 3 5gm PO or amoxicillin. 3 0gm PO, each as a single dose with 1 0gm of probenecid PO, followed by 7 days of tetracycline or doxycycline therapy as above.

For penicillin-resistant strains: 2gm of spectinomycin (Trobicin) or cefoxitin (Mefoxin) IM. The latter should be given with probenecid

Outpatient regimen is the same as for uncomplicated gonorrhea except that doxycycline 100mg PO, BID should be given 10 to 14 days following initial single-dose therapy with cefoxitin, amoxicillin, ampicillin, or penicillin G plus probenecid. Hospitalize if questionable diagnosis, severely ill, or poor response, and see reference 9 for treatment.

Local therapy (e.g., sitz baths with thorough drying), analgesics; acyclovir (Zovirax, 5% ointment or parenteral) is helpful in initial infections, and may be slightly helpful in recurrent disease

Miconazole or clotrimazole, vaginal cream suppositories

Metronidazole, 2.0gm PO, as a single dose

Metronidazole, 500mg PO, BID for 7 days

They also are relatively resistant to tetracyclines, but are sensitive to spectinomycin, cefoxitin, and the third generation cephalosporins. Only a few such strains have been isolated in Indiana, and most apparent treatment failures represent re-infections rather than resistant strains.

#### Genital Herpes

It is estimated that in the United States there are approximately 500,000 new cases of genital herpes per year, and that approximately 5 million people have been infected. Herpes simplex virus (HSV), Type 1, causes the common "cold sore"

or "fever blister," while Type 2 virus is associated with genital disease. However, either type can occur at either site.

Almost 90% of patients who acquire a primary genital infection with Type 2 virus develop clinically evident recurrent disease, while only about 50% of those infected in the genital area with Type 1 virus experience recurrence. However, the frequency of recurrences is highly variable. Some patients have one every few weeks, while others may go more than a year between episodes.

Some of the differences in the clinical course of primary and recurrent disease are summarized in *Table 4*. Major symp-

toms of primary infection include genital pain, dysuria, urinary retention, vaginal discharge, and painful inguinal lymphadenopathy. The lesions are relatively numerous (15 to 20), and usually bilateral. They begin as vesicles, progress to pustules, and then form wet ulcers. The ulcers crust and heal with little or no scar formation. Virus can be isolated from the majority of vesicular and ulcerative lesions, but by the time crusting has occurred the yield of viral cultures drops below 50%. Many patients with primary infections also have systemic manifestations including fever, malaise, and meningeal irritation.

One or two days prior to a recurrence there is often a prodrome consisting of itching, burning, or paresthesias in the area where the lesions will appear, and virus may be recovered from the skin during this phase. In general, recurrent episodes tend to be milder, of shorter duration, and to lack the systemic manifestations associated with primary infections (*Table 4*).

The diagnosis can usually be established by the clinical appearance of the lesions, although many patients and physicians prefer to obtain viral cultures for confirmation. Serologic testing is not useful except in a research setting. Recurrent disease in the absence of a history of primary disease is often much more difficult to diagnose, since the ulcers may be very few in number and not have the typical herpetiform appearance. In that case viral culture, along with exclusion of other likely diseases, is the only means to establish the diagnosis. Between occurrences the virus exists in a latent state in the sacral ganglia. Factors which provoke recurrence vary from patient to patient, but often stress, including such things as menstruation or psychological problems, can be identified as provocative factors.

There is an epidemiological association with genital carcinoma, and women with a history of genital herpes should be screened with routine Pap smears at least once per year. There is also a risk of transmission of the virus to a neonate at birth. Fortunately, this is a relatively rare complication. Moreover, delivery by

cesarean section at term (while the membranes are intact, or within six hours of membrane rupture) can substantially reduce the risk of neonatal infection in women with active genital lesions. Consequently, all pregnant women should be questioned carefully about a history of genital herpes, and those with a positive history should be screened throughout pregnancy with a weekly viral culture of the cervix. In addition, any genital lesions which occur after the 36th week of gestation should be cultured. Any patient with a positive culture within one week of delivery should be considered for cesarean section. This type of close observation permits most women with a history of genital herpes to have vaginal deliveries, and genital herpes should not be considered even a relative contraindication to pregnancy.

Counseling of patients with genital herpes regarding their sexual activity is somewhat more difficult. There are individuals without any history of genital lesions who shed HSV from the genitals intermittently, and others who have a history of lesions who shed virus at times when no lesions are present. However, such people do not appear to be highly infectious. As a practical matter, patients are usually advised to consider themselves infectious during the prodromal period, and/or when they have active lesions.

Treatment is primarily supportive. Local measures such as sitz baths and drying of the infected regions (e.g., hairdryer) are important. Also, patients should be advised to wear non-occlusive underwear, and to not apply occlusive creams or ointments. Of the numerous agents which have been evaluated, only acyclovir (Zovirax) has so far been demonstrated to have any efficacy in treating genital herpes.11 The topical form, when applied during primary disease, shortens the duration of the lesion formation and of viral shedding. Its effectiveness during recurrent disease is much less well documented, but it may slightly shorten the duration of new lesion formation if applied during the prodromal phase. The intravenous form is useful for the treatment of the occasional

TABLE 4
Characteristics of Primary and Recurrent Genital Herpes

Characteristic	Primary Disease	Recurrent Disease	
Average duration of symptoms	10 days	4 days*	
Average duration of lesions	16 days	10 days	
Average duration of viral shedding	9 days	4 days	
New sex partner in last 30 days	+ + +	+	
Prodrome	0	+ + +	
Fever	+ + + + *	0	
Aseptic meningitis	+ *	0	
Pharyngitis	+	0	
Autoinoculation of distant			
body sites	*	0	
Bilateral lesions	+ + + +	+	
Involvement of cervix	+ + + +	+	
Inguinal lymphadenopathy	+ + +	0	

Code 0 = seen in < 5% of patients, + = seen in 5% to 25%, + + = seen in 25% to 50%, + + + = seen in 50% to 75% + + + + = seen in > 75% \*Frequency or duration somewhat greater in females than in males

TABLE 5 Syphilis Serologies

	Percentage of infected patients with Positive Tests	
	Nontreponemal	Treponemal
	(VDRL or RPR)	(FTA-ABS)
Stage of Disease		
Primary	76	90
Secondary	100	100
Tertiary	72	97
Late Latent	70	95

Abbrevations: VDRL, Veneral Diseases Research Laboratory (slide test); RPR, Lapid plasma reagin; FTA-ABS, fluorescent treponemal antibody, absorbed

patient with severe primary disease.

An oral preparation is currently undergoing clinical trials, and appears to be effective in preventing recurrent disease in about 80% of patients who take it on a continuous basis. However, recurrences begin again when it is discontinued. 13,14 lts role in the management of patients with genital herpes requires further definition.

#### Condyloma Acuminatum

Condyloma acuminata, or genital warts, are caused by human papilloma viruses. These viruses have not yet been

cultivated in tissue culture, and relatively little is known about them. However, epidemiological data indicate that the route of transmission is sexual. Between 50% and 70% of exposed partners of patients with genital warts develop genital warts themselves. The incubation period appears to be about one to two months, but may be longer in some cases. Warmth and moisture seem to accelerate their growth.

Genital warts are strongly associated epidemiologically with genital carcinoma, and papilloma virus DNA has been demonstrated in several such malignancies. It has recently been suggested that papilloma viruses may, in fact, be a primary cause of cervical carcinoma, and HSV but one of several agents which can act synergistically with them. <sup>14</sup> They can be transmitted from mother to child at birth, in which case they may cause laryngeal papillomas in the infant. Intraoral infection in adults can also be acquired during oral-genital sexual contact.

There is no consensus as to optimal therapy. Podophyllin has been used for many years, but is relatively ineffective. It should be avoided in pregnancy since there is some absorption and it is potentially teratogenic. Recurrence rates after excisional surgery approach 40%. Cryotherapy or removal with a CO<sub>2</sub> laser is probably optimal in most settings. Intraurethral warts should be treated with 5-fluorouracil (5% cream).

### **Syphilis**

Syphilis remains a medical problem, particularly in homosexual males. All patients presenting with a sexually transmitted disease or with a lesion suggestive of primary syphilis should have a serologic test for syphilis performed. If they are then treated for something else (e.g., gonorrhea) with a regimen known to abort incubating syphilis, further blood tests are not necessary. However, if they

are not, then they should have a repeat scrology in two to four weeks.

Postive non-treponemal serologies (i.e., VDRL or RPR) should be confirmed with a specific serology, the FTA-ABS. False-positive VDRL or RPRs are relatively common, while false-positive FTA-ABS are extremely rare. As indicated in *Table* 5 the VDRL may become negative even in untreated syphilis but once positive, the FTA remains positive for life. 16

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## OLIGURIA: A Frequent Problem in the Critically III Patient

THEODORE F. HEGEMAN, M.D. Indianapolis

LIGURIA is one of the most frequent fluid and electrolyte problems observed in hospitalized patients and is the most ominous. Etiologies vary from inadequate renal perfusion to structural renal insults. The rapid, systematic approach to oliguria may obviate the potentially complex therapeutic intervention, dialysis.

Water excretion represents the difference between the amount of fluid filtered from the blood and the amount reabsorbed as the filtrate passes through the nephrons. With normal renal function, some 160 liters of water are filtered at the glomeruli daily. Urine volume averaging several liters results from reabsorption of the vast majority of the water by the tubules. Loss of glomerular function, per se, only affects urine volume at the extreme of renal dysfunction, whether acute or chronic. Even with a 50% or 75% decrease in glomerular filtration rate, the amount of water entering the tubule is much larger than urine volume by a factor of 20 or more.

Oliguria means scanty urine. A specific level of output is necessary for clinical use. The level chosen is the minimal volume of urine into which the kidneys can excrete all wastes to avoid their retention. Catabolism produces about 600 mOsmoles of osmotically active wastes each day that require renal handling. With maximum concentration (1200)

mOsm/kg. of water), 500 cc. of urine is, then, the minimum volume necessary for their removal and, thus, defines oliguria.

Once recognized, oliguria demands a rapid evaluation. Systematically, possible corrective causes must be considered. The myriad etiologies fall into three general groups (see *Table 1*). Obstruction must always be considered. Anuria is seen with

The Rapid,
Systematic Approach
to Oliguria
May Preclude
the Potentially
Complex Therapeutic
Intervention—
Dialysis . . .

complete bladder outlet or bilateral upper tract obstruction. However, partial bladder outlet obstruction can produce oliguria. In addition, a variety of combinations of intrinsic renal disease and obstruction involving one kidney with one process and the other with a second may also lead to oliguria. Bladder catheteriza-

tion and ultrasonography are simple, relatively noninvasive studies that will rapidly document the patency of the bladder outlet and the lack of hydronephrosis from upper tract obstruction. These should be performed if any possibility of obstruction is present in the oliguric patient.

Pre-renal factors leading to oliguria are many, sharing the ineffective perfusion of the kidneys and hence the glomeruli. The result at the nephron level is an increased reabsorption of sodium and water throughout the tubule to preserve intravascular volume. A concentrated, scanty urine results. A number of tests to differentiate the pre-renal state from intrinsic renal failure are based upon the avid reabsorption of sodium and water in the former. All of these tests, as listed in Table 2, require only a spot urine sample and a simultaneous blood test. They characterize pre-renal urine as having a low urine sodium concentration, a high osmolality, and high solute levels such as urinary urea nitrogen (UUN) and creatinine because of the concentrated nature of the urine. The fractional excretion of sodium (FeNa) relates sodium excretion to the amount of sodium filtered, taking into account decrease in glomerular filtration rate which is seen, even in pre-renal situations. Unfortunately, overlap of results has been described with all of these tests, making them nondiagnostic. However, when combined with clinical information, the indices can be helpful in complex situations.

Oliguria secondary to pre-renal factors is potentially reversible. The best clinical approach is through a complete history and physical examination. The quantity of fluid intake and output over the recent past should be assessed, looking for abnormal losses. A history of heart and liver disease is sought. Potential drug effects—diuretics, vasoconstrictors, etc.—are

From Nephrology and Internal Medicine, Inc., 1633 N. Capitol Ave., Indianapolis, Ind. 46202.

### Table 1 Differential Diagnosis of Oliguria

Obstructive Uropathy
Lower Tract
Bilateral Upper Tract
Unilateral Upper Tract with Contralateral
Intrinsic Disease

Pre-Renal Azotemia
True Volume Depletion
Ineffective Intravascular Volume

Intrinsic Renal Failure
Microvascular and Glomerular Disorders
Macrovascular Catastrophies
Classic Acute Tubular Necrosis—75% of Acute
Renal Failure (ARF)

Table 2 Urinary Parameters					
<u>Test</u>	Pre-renal_	ARF			
UUN/BUN	> 20/1	< 10/1			
U/P <sub>Cr</sub>	> 40/1	< 10/1			
$U/P_{Osm}$	> 1.5	< 1.5			
$U_{Na}$	< 20	> 20			
Fe <sub>Na</sub> (%)	< 1	> 3			
	$Fe_{Na} = \frac{U_{Na} / P_{Na}}{U_{Cr} / P_{Cr}} \times 100$	°/o			

reviewed. The physical examination aims at the state of intravascular volume. Tissue turgor, presence of edema, signs of congestive heart failure, and orthostatic fall in systolic blood pressure greater than 30 mmHg., are all helpful, whether present or absent. Finally, if most evidence points to an inadequate intravascular volume, fluid challenging in one form or another should be performed immediately! This can be in the form of small aliquots of fluid at frequent, repetitive intervals administered until a certain level of intravascular pressure is reached or simply estimating fluid needs over the next 12 to 24 hours and increasing these in a dramatic way by adding replacement for suspected deficits. The latter is favored in most cases in that significant dehydration may result in an extremely large volume of losses and small challenges will not meet the need.

Monitoring of such volume administration depends upon the overall stability of each patient. Certainly, daily weights, intake and output records, and monitoring of blood pressure, as well as frequent, repetitive examinations by a physician are needed. In the healthy young person who is dehydrated, this may be all that is necessary. However, if inter-current illness that may modify the usual markers of fluid overload is present, more aggressive monitoring such as with pulmon-

ary artery catheters is mandatory. These can be easily placed and monitored in most facilities. Certainly, the more data available, the better care that can be delivered to the patient.

The value of diuretics to potentially ameliorate acute renal failure is unproven. In general, pre-renal conditions will respond to improvement of the pre-renal component. The diuretics should always be reserved until adequate intravascular volume is obtained and then only administered in moderation as side effects are possible.

Intrinsic renal diseases as etiologies for oliguria fall into three general categories. Microvascular, as well as large vessel processes, are distinctly uncommon and difficult to diagnose. They should be considered more strongly when no apparent etiology for the third group is present. Interventive techniques—biopsy or arteriography—are necessary for their diagnosis.

Much more commonly, an ischemic or nephrotoxic insult can be identified. In history taking, one should search for any and all toxic exposures. Ischemic insults severe enough to lead to acute renal failure should be evident from a complete history which includes review of any preceding hospital records. Once the evidence is overwhelming that acute renal failure is present, a plan needs to be

developed for future monitoring. Fluid intake should be exceeded by total fluid output such that the patient loses one-half pound of weight a day, allowing room for fluid shifting from the intracellular compartment to the intravascular space from catabolism. Such movement of fluid can lead to congestive heart failure just as excessive administration of fluid to the patient can. Acidosis and hyperkalemia must be looked for closely to avoid potentially lethal levels. Finally, azotemia is monitored daily to plan for possible dialytic intervention.

#### Summary

The presence of oliguria raises the possibility of severe renal insult that may require dialytic intervention. Reversible causes, pre and post renal, must be sought in a systematic fashion. A thorough history and physical examination is necessary, paying attention to fluid and salt balances as well as potential renal insults. Correction of pre-renal problems through volume administration may require sophisticated intravascular monitoring. Once all reversible factors have been excluded through both evaluation and possibly active intervention, fluid restriction along with careful observation of potassium concentration, hydrogen ion concentration, and BUN and creatinine levels is necessary.

### Safety Seat Use in Indiana Prior to Mandatory Legislation

KAREN BRUNER STROUP, M A
MARILYN J. BULL, M.D.CARIJANE ALLEY, B.A
JOHN L WILLIAMS, Ph D.Indianapolis

OTOR VEHICLE-RELATED deaths and injuries of infants and children are a persistent health problem in the United States. On a national basis, more children are injured or killed in automobile accidents than from diseases such as cancer, heart disease and pneumonia.1 The National Safety Council reports that approximately 1,200 children under the age of 5 years died while 50,000 children were injured in motor vehicle-related accidents in 1982.2 The economic costs to society are as equally staggering.3,4 One recent estimate projected a per case cost of \$200,000 for motor vehicle fatalities, which includes

Research Associate, Automotive Safety for Children Program, Riley Hospital.

Associate Professor of Pediatrics and Director, Automotive Safety for Children Program, Riley Hospital.

Education Specialist, Automotive Safety for Children Program, Riley Hospital. Human Communications Consultant.

Correspondence: Marilyn J. Bull, M.D., Riley Hospital, Rm. P-121, Indiana University School of Medicine, 702 Barnhill Drive, Indianapolis, Ind. 46223.

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#### Abstract

A study was developed and directed by the Automotive Safety for Children Program at James Whitcomb Riley Hospital for Children to provide information on safety seat and seat belt use for children prior to Indiana's child passenger restraint law. The survey was conducted from September to mid-November 1983 at 12 sites in Indiana in both urban and rural areas.

A total of 2,732 observations of adults and young children were made on 910 vehicles, including 124 infants from birth

to 12 months and 827 toddlers from one through four years. Most of the children from birth through age 4 were unrestrained. A total of 596 (63%) children in this age group were not protected by either a lap belt or car seat. This survey also found that 205 (71%) of the 287 children observed in a car seat (or 21% of the total sample of 951 infants and toddlers) were incorrectly restrained in the seat. Of the total 951 observations made of children from birth through age 4, 150 (16%) were restrained properly in either a safety seat or seat belt.

medical expenses, property damage, insurance administration, and wage loss.<sup>5</sup>

In Indiana, approximately 25 children under 5 were killed while over 1,500 in this age group were injured as passengers in motor vehicle accidents annually between 1981 and 1983.6 Efforts have been made in Indiana to educate the public on the importance of this health problem, and Indiana's mandatory child passenger restraint law was passed to help increase the use of safety seats for young children in motor vehicles. The law, which became effective Jan. 1, 1984, requires children under 3 to be properly fastened and restrained in a federally approved safety seat. Children from 3 to 5 may be restrained either by a safety seat or a seat belt. The law applies to all drivers of private vehicles registered in Indiana. Failure to comply with the law is a Class C infraction, which carries a fine of \$25 to \$500.

A study was developed and directed by the Automotive Safety for Children Program at James Whitcomb Riley Hospital for Children to provide information on safety seat and seat belt use for children prior to Indiana's child passenger restraint law. The results of this study will provide baseline data for evaluating the effectiveness of Indiana's law in increasing the use of child restraints. A follow-up survey is being conducted this fall at the same sites visited for the initial study. The purposes of the Indiana study were to determine (1) rates for correct, incorrect, and non-use of restraint devices and (2) types of misuse occurring in different styles of car seats.

### Materials and Methods

In September 1983, two full-time staff members, the director of the Automotive Safety for Children Program, a registered nurse consultant with the Indiana State Board of Health, and a doctoral student in the Indiana University School of Nursing completed survey training. Classroom instruction reviewed 30 different styles of car seats and misuses occurring with each style.

Observers were certified after completion of a one-hour examination, which tested knowledge of different car seat styles, correct and incorrect uses of car seats, and the ability to record accurately when a car seat was being used correctly or incorrectly. A passing level of competency on the test for observers was set at 90%. All survey observers met or exceeded the desired competency level.

The survey form listed: (1) ages of motor vehicle occupants, (2) restraint use by adult passengers, (3) restraint use by ehildren ages 5-15 years, (4) restraint use for children ages 1-4 years, and (5) restraint use by infants from birth to 12 months. If a safety seat was used, the name of the seat was indicated. If a seat was incorrectly used, the form of misuse was noted.

The survey was conducted from September to mid-November 1983 at 12 sites in Indiana in both urban and rural areas. The sites were: Anderson, Terre Haute, Merrillville, Fort Wayne, Jasper, Mishawaka, Logansport, Batesville, Evansville, Rushville, Bloomington and Indianapolis (Table 1). All observation studies were conducted at main entrances or exits of shopping center sites. Observers were stationed at locations in the shopping center where there was a traffic light or stop sign, little chance for a traffie build-up to occur, and no highrisk for personal safety, i.e., an embankment was present to stand on; safety vests were worn for visibility.

A state police officer stopped vehicles for observers at each site. Passenger ears



OBSERVERS interview driver and observe car seat use from both sides.

selected for observations met three requirements: (1) contained one or more child passengers, (2) were stopped at stop lights or traffic signs, and (3) could be stopped without obstructing traffic. The data collection occurred from 10 a.m. to 4 p.m., a time frame that was chosen for the greater likelihood of observing small children in motor vehicles.

#### Results

The dBASE 11 database management system was used to compute the results

of this survey. A total of 2,732 observations of adults and young children were made on 910 vehicles, including 124 infants from birth to 12 months (*Table 2*) and 827 toddlers from 1 through 4 years (*Table 3*). The results discussed here combine both categories since Indiana law applies to children from birth through age 4.

Unrestrained Passengers. Most of the children from birth through age 4 were unrestrained. A total of 596 (63%) children in this age group were not protected by either a lap belt or car seat. Of this

	TA	BLE	1
Distri	bution	of Ol	oservations
by	Site o	f Obse	ervation

Site	Number	Percent
Anderson (Mounds Mall)	159	5.8
Terre Haute (Honey Creek Square)	343	12.6
Merrillville (Century Consumer Mall)	157	5.8
Fort Wayne (Times Corners Shopping		
Center)	130	4.8
Jasper (3-D Plaza Shopping Center)	276	10.1
Mishawaka (University Park Mall)	144	5.2
Logansport (Logansport Mall)	259	9.5
Batesville (McDonald's Restaurant and		
shopping center entrance)	259	9.5
Evansville (Eastland Mall)	325	11.9
Rushville (3-D Plaza Shopping Center)	209	7.7
Bloomington (College Mall)	319	11.6
Indianapolis (Lafayette Square)	152	5.5
TOTAL.	2,732	100.0

#### TABLE 2 Infant\* Occupant Restraint Use Indiana 1983

Restraint Use Category	Infant	Occupants
Safety Seat Correctly Used	Number 17	Percent 13.8
Safety Seat Incorrectly Used	49	39.6
Infant Carrier Used	2	1.6
Safety Seat in Car Not Used—Child Unrestrained	8	6.4
Held in Lap	34	27.4
Unrestrained	14	11.2
TOTAL	124	100.00
*Birth to 12 months		

group, a total of 81 (14%) were riding on an adult's lap. Infants from birth to age 1 were placed in the greatest danger of injury or death by being lap held. Of the 56 infants observed who were not restrained, 34 (61%) were lap held while only 47 (9%) of the 540 unrestrained toddlers were lap held.

Results of this survey also showed that seat belt use was not prevalent for older children (*Table 4*) or adults (*Table 5*). Three hundred and fifty-four (88%) of the 403 children from 5 to 15 years of age were unrestrained in the car. Ninety-one per cent of the 1,378 adults were unrestrained.

Correctly Restrained Infants and Toddlers. Of the total 951 observations made of children from birth through age 4, 150 (16%) were restrained properly in either a child restraint device or a seat belt. Correct installation of the safety seat into the car was defined as using all essential parts (harness straps, shield, tether), reclining the seats in the correct position, and anchoring the seat correctly according to manufacturer's directions with the seat belt. Only 82 (29%) of the 287 infants and children observed in a car seat were correctly restrained.

Incorrectly Restrained Infants and Toddlers. Indiana law specifically requires that a child be restrained properly in a car seat. This survey found that 205 (71%) of the 287 children observed in a car seat (or 21% of the total sample of 951 infants and toddlers) were incorrectly retrained in the seat.

Major misuses included: (1) placing in-



OBSERVER notes infant properly restrained but toddler standing on rear seat.

fants forward facing instead of rear facing in safety seats, (2) failure to use a required tether strap; (3) misrouting the seat belt around the frame of the seat to the seat of the motor vehicle; (4) failure to use a required shield; and (5) use of a seat that did not meet federal motor vehicle standard 213. This standard, which took effect Jan. 1, 1981, requires that all seats manufactured after that date meet specific safety requirements in simulated 30 m.p.h. crash situations using dummy representatives. Seats manufactured prior to that time may not meet all of the requirements of this standard.

The misuse rate was highest for infant seats. While 68 infants were restrained, 51 (75%) of the seats observed were being used incorrectly. In the toddler category, 154 (70%) of the 219 safety seats observed were misused.

#### Discussion

The findings of this study provide one indication of the use of restraints by Indiana's drivers and riders prior to the effective date of legislation requiring the use of restraints for young children. One factor that may have affected the percentages reported was that the level of awareness of restraint use may have been higher at the time of the study since the law had been passed in April 1983 and publicity in local communities about the law's requirements accelerated prior to its effective date.

Restraint use was highest for infants and decreased with the age of the child (*Table 6*). Restraint use (including correct and incorrect use figures) was highest for infants (55%) and decreased to 35% for toddlers and 12% for older children. The growth of car seat loan programs in Indiana may have contributed to the higher usage rate of child restraints for infants. Most parents receive this information through initial contact with informed hospital personnel as a family prepares to return home.

It was anticipated that the numbers of unrestrained children would be high and that many younger children would be lap held. As noted by Williams, on-lap travel is common and increases the likelihood

	TABLE	3	
Toddler*	Occupant	Restraint	Use
	Indiana I	983	

Restraint Use Category	Toddler	Occupants
	Number	Percent
Safety Seat Correctly Used	65	7.9
Safety Sear Incorrectly Used	154	18.7
Safety Seat in Car Not Used—Child		
Unrestrained	37	4.5
Lap Belt Used	68	8.2
Held in Lap	47	5.6
Unrestrained	456	55.1
TOTAL	827	100.0
*1-4 years		

TABLE 4
Older Child Occupant Restraint Use
Indiana 1983

morana 120	,,,	
Restraint Use Category	Number	Perceni
Lap Belt	32	7.9
3-Point Harness	17	4.3
Held in Lap	15	3.7
Unrestrained	339	84.1
TOTAL	403	100.0

TABLE 5 Adult Motor Vehicle Occupant Restraint Use Indiana 1983

Restraint Use Category	<u>Number</u>	Percent
Lap Belt	15	1.0
3-Point Harness	103	7.5
Passive Restraint	3	0.2
Unrestrained	1,257	91.3
TOTAL	1,378	100.0

of injury to children by the person holding them. Pediatricians and obstetricians should counsel patients of the need to protect infants and young children with seat belts and safety seats and all adult passengers with seat belts. Pregnant women should wear seat belts to protect themselves and unborn children.

This study's findings on misuse of car seats emphasize the importance of educating parents on the correct use of safety seats. Shelness and Jewett found in their study of observed misuse of car seats in parked motor vehicles that 75% of the car seats examined had errors in belt routing, tether use, or both.8 While another 19 city surveys of car seat use found that 8.8% of the infant seats were misused and 5.2% of the toddler seats were not installed properly, the lower rates can be attributed to less rigorous criteria for misuse.9 More attention must be directed toward educating parents on how to properly use a car seat. Providing information that clearly shows and explains proper use of the car seat is essential and is a serious issue that must be addressed by manufacturers, car seat loan programs, health professionals, and retail stores that sell car seats to the public.

Among the steps that could be taken to educate the car seat consumer are:

- 1. Direct the parent to identify the date of manufacture for the seat, which is usually located on the back of the safety seat. If the seat was manufactured prior to Jan. 1, 1981, it may not meet all or any of the requirements of federal motor vehicle safety standard 213.
- 2. Provide an opportunity for the parent to use the seat under the supervision of an informed instructor in a hospital or retail setting.
- 3. Sponsor public displays or public service announcements on car seat use in conjunction with other health and safety organizations to call attention to the importance of not only using a child restraint device, but of using it correctly.
- 4. Educate appropriate staff members on general guidelines for correct car seat use so that this information is shared with the general public.

Indiana's child passenger safety law provides a beginning for attaining increased usage of child restraint devices. In Tennessee, where mandatory legislation has been in effect since 1978, safety seat usage rates increased from 8% before the law to 29% in 1980.10 However, health and safety professionals must continue to play an active role in the education process of proper car seat use for Indiana's law to be optimally effective.

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TABLE 6 Observed Restraint Use Among Indiana Motor Vehicle Occupants, 1983

Occupant Category	Percent Restrained*	
Infant	14	
Toddler	8	
Adult	9	

\*All percents were within the 95% confidence level. Percent restrained refers to proportion correctly restrained. The percentage of adult use of seat belts in Indiana parallels the national percentage range of 14% reported by the National Highway Traffic Safety Administration.

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### Solitary Rectal Ulcer Syndrome

AMARJIT S. KOCHAR, M.D.<sup>1</sup> TSAU-YUEN HUANG, M.D.<sup>2</sup> AMADOR A. ACOSTA, M.D.<sup>1</sup>

### Key Words

Ulcer, rectal Solitary rectal ulcer syndrome Prolapse, rectum Prolapse, uterus

#### Abstract

Solitary rectal ulcer syndrome is a rare condition of unknown etiology. A case is reported of a 76-year-old woman clinically presenting with prolapse of the rectum and uterus, masquerading as carcinoma of the rectum. Recent literature and pathogenesis of this entity are briefly reviewed and discussed.

From the Dept. of Pathology, St. Mary Medical Center, Gary and Hobart, Ind.

Staff Pathologist, St. Mary Medical Center; Clinical Assistant Professor of Pathology, Indiana University School of Medicine, Northwest Center for Medical Education, Gary, Ind.

Staff Pathologist, St. Mary Medical Center; Clinical Associate Professor of Pathology, Indiana University School of Medicine, Northwest Center for Medical Education, Gary, Ind.

Correspondence and reprints: Amarjit S. Kochar, M.D., Dept. of Pathology, St. Mary Medical Center, 540 Tyler St., Gary, Ind. 46402.

OLITARY RECTAL ULCER SYNDROME is a rare condition of obscure etiology that was first reported by Cruveilheir approximately 150 years ago. Since then several case reports and review articles have appeared in the medical literature. 2.6,7,12 The condition is not widely recognized. It is important for both surgeons and pathologists to be familiar because it may be confused both clinically and histologically with carcinoma, and such a mistaken diagnosis may lead to unnecessary excision of the rectum. We report here a case of an elderly woman who presented with complete prolapse of the rectum and uterus which endoscopically mimicked carcinoma.

### Case Report

A 76-year-old white woman was admitted in March 1983 because of a sudden onset of rectal bleeding accompanying bowel movements. Significant past history included admission for chronic diverticulitis four years prior to the present hospitalization. She had had regular bowel movements and denied a history of constipation. Physical examination revealed complete prolapse of the rectum and complete prolapse of the uterus. The prolapsed rectum appeared markedly edematous and bluish. It was reduced in the surgeon's office and she was admitted for further evaluation and management. The only abnormal laboratory finding was a mild degree of normocytic normochromic anemia.

Colpocleisis and posterior colporrhaphy were preformed as corrective surgery for uterine prolapse. At the time of this surgery, proctoscopy was performed by the general surgeon who noted a large polypoid friable ulcerated mass in the rectum, 5 cm from the anal verge. Multiple biopsies were obtained from this mass and were interpreted, on frozen section, as an inflammatory process. Proctosigmoidoscopic findings were highly suspicious for underlying malignancy. Because the lesion was partially obstructing, it was elected to do a low anterior resection of the rectosigmoid colon (Hartmann procedure). The operative findings also disclosed stricture formation of the sigmoid colon due to chronic diverticulinic

### Pathologic Findings

The specimen was an 11.5 cm segment of rectosigmoid colon. There was a fairly well demarcated large ulcerated lesion encircling the colon and measuring  $7.2 \times$ 4.5 cm. This lesion contained multiple raised polypoid masses and there was approximately 50% luminal narrowing at the site of the lesions (Figs. 1 and 2). The base of the ulceration was covered by vellowish fibrinopurulent exudate. A small satellite ulceration was also present in addition to the main lesion. Histologic sections revealed extensive granulation tissue formation at the ulcer bed (Fig. 3). The superficial exudate consisted of polymorphonuclears and fibrin. Focal areas of increased smooth muscle and fibrous tissues were present, especially in the polypoid masses. Culture of the yellowish slough from the ulcer yielded normal bowel flora only.

#### Discussion

Solitary rectal ulcer syndrome is a benign condition with a chronic course that occurs predominantly in young adults of either sex. The name may be misleading because there may be more than one ulcer and there appears to be a stage of the disease when no ulceration is present. Clinically and histologically, a recognizable pre-ulcerative phase in the form of hemorrhagic proctitis or nonspecific proctitis has been reported. The condition may present with any of the diverse symptoms of anorectal disease. Rectal bleeding is the most common and may be severe enough to require transfu-



FIGURE 1: Large circumferential polypoid ulceration.

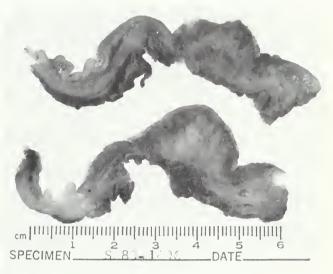


FIGURE 2: Cross sections through the ulceration revealing marked thickening of the rectal wall.

sion. One of the two cases reported by Lifschultz *et al.*<sup>5</sup> was unusual, as fatal hemorrhage resulted when the ulcer eroded into a large serosal artery. Other common symptoms of this condition include passage of mucus, perineal pain and tenesmus. There may be associated rectal prolapse as reported in several publications, <sup>6,7,8,9</sup>

In a series of 51 patients reported by Martin et al., 6 91% of the patients were noted to have abnormal descent of the rectal wall, and two-thirds of these had rectal prolapse to or beyond the anal verge. Their results also indicated healing of the ulcers following surgical correction of the prolapse. The location of the ulcers is generally on the anterior or anterolateral wall and their size varies from 0.5 to 3 cm. Large circumferential ulcers, as seen in our patient, are rare. The histologic hallmark of the condition is obliteration of the lamina propria by smooth muscle and fibrous tissues. In some cases there is a misplacement of mucus-filled glands lined by normal colonic epithelium into the submucosa, which may be mistaken for carcinoma.

Some of the uncommon features present in our case were older age of the patient, large circumferential lesion with partial bowel obstruction and satellite ulceration. The etiology of the solitary

rectal ulcer syndrome remains unknown, but there is considerable evidence that the combination of mucosal prolapse, trauma and ischemia caused by excessive straining at stool may be important factors. <sup>10</sup> In many cases there is electromyographic evidence of failure of the normal mechanisms in the pelvic floor, which control continence and defecation and, in particular, the activity of the puborectalis muscle. <sup>11,12</sup>

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FIGURE 3: Granulation tissue formation and obliteration of lamina propria by smooth muscle and fibrous tissue.

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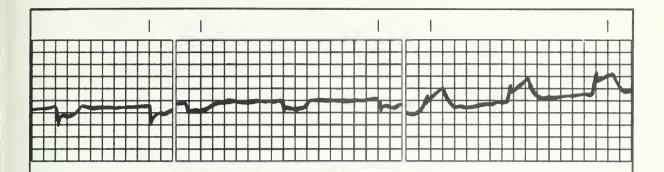
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### Digitalis Toxicity: A Review of the Literature

STEPHEN P. MOENNING, MD. Grand Rapids, Mich.

IGITALIS, used by Withering some 200 years ago, is a remarkable and unique drug in medical annals. It has been and continues to be of considerable interest to many people of varying disciplines.1 For these 200 years physicians have been struggling with the digitalis glycosides because of their high degree of toxic-therapeutic variability.2 Because of the variability, digitalis is one of the most common causes of cardiac arrhythmias; almost any arrhythmia may be caused by the drug.3 It is estimated that from 6 to 20%4 of patients on digitalis may be toxic, with signs and symptoms depending on the health of the patient and on whether the toxicity is acute versus chronic.5-11

The electrocardiogram (ECG) has become the most sensitive index of digitalis intoxication. 12 Thus, it becomes important to distinguish ECG changes induced by moderate doses of digitalis, which require no changes in therapy, from those that indicate toxicity and call for discontinuation of the drug. 13 This presents a therapeutic dilemma to the physician because arrhythmias for which

digitalis is used for control may be induced by its use. Although some arrhythmias, per se, have a high degree of specificity as an index of digitalis toxicity, a definitive statement that a given arrhythmia is due to digitalis cannot be based solely on ECG manifestations. In addition to the ECG changes, one must be aware of predisposing factors to toxicity and systemic manifestations. <sup>14</sup> This article will touch upon the pharmacology, predisposing factors and toxic systemic manifestations of digitalis, in addition to lending insight to the various arrhythmias seen in the digitalis toxic patient.

Digoxin and digitoxin are the most widely used purified cardiac glycosides in the United States and probably in the world. Digoxin is 75%-85% absorbed when taken orally, and excreted unchanged principally in the urine. Optimum serum levels are 0.5 to 2.5 micrograms/ml; more than 3.0 micrograms/ml is almost always toxic in adults.15 Digitoxin is 100% absorbed when taken orally and it is extensively metabolized and excreted in stool and urine as a cardioinactive metabolite. Optimum serum levels of digitoxin are 20 to 35 micrograms/ml and toxicity is usually associated with a level greater than or equal to 45 micrograms/ml.15

Testing of the serum digitalis level is easily justified because it offers another objective measurement to confirm the clinician's judgment of under-or-over-digitalization.<sup>15</sup> The test also helps in directing the digitalization of patients with an impairment of renal function or gastrointestinal absorption.<sup>16</sup> Doherty<sup>15</sup> has compared the serum digoxin concentration to the clinical estimates of "toxic" vs. "nontoxic" in 100 human subjects. He found that at the same digoxin concentration, an overlap between those patients throught to be toxic and those

clinically nontoxic did occur. Thus, the clinician must not rely solely on the serum level for a determination of toxicity; instead, he must utilize cautious judgment in evaluating these results.

Digitalis toxicity may be provoked and manifested by many factors. The underlying cardiac status, electrolyte disturbance and the endocrine status all play a role in determining toxicity. <sup>17</sup> Advanced heart disease, regardless of cause, narrows the therapeutic to toxic ratio and increases the incidence of digitalis intoxication <sup>18,19,20,21</sup> and a higher incidence is reported in patients with acute infarction. <sup>22,23</sup> Similarly, a larger percentage of patients with coronary artery disease had signs of intoxication at lower serum levels, <sup>19</sup> and patients with the above findings may even have toxicity at "normal" levels.

Doherty et al.,24 have shown that following comparable doses of digoxin, the serum concentration of digoxin is higher in patients with congestive heart failure and renal failure than it is in patients wth congestive heart failure alone. Doherty<sup>15</sup> also has shown a highly significant positive correlation between creatinine clearance and the clearance of digoxin. One must closely follow the renal impaired patient for signs of toxicity and be prepared to alter the dosage appropriately. No modification of digoxin dosage is necessary in liver disease, provided hypomagnesemia can be ruled out. The same is true for digitoxin despite its almost total hepatic metabolism.14

Numerous drugs may alter the plasma digoxin concentration (PDC). Belz et al., <sup>25</sup> in a prospective randomized study of 36 healthy men, demonstrated a daily verapamil dose of 240 m.g. led to a 70% increase in the PDC and nifedipine increased the PDC 45%. Klein et al., <sup>26</sup> found verapamil's effect on the PDC to occur gradually; 90% of the increase was

The author was a senior medical student, Indiana University School of Medicine, and was engaged in a Cardiology rotation at the Veterans Hospital, Indianapolis, at the time of this writing.

Correspondence: Blodgett Memorial Medical Center, Dept. of Surgery, 1840 Wealthy, S.E., Grand Rapids, Mich. 49506.

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observed 14 days after the onset of the drug. Doering<sup>27</sup> reported that coadministration of verapamil and quinidine with digoxin resulted in a 155% increase in the PDC, and he concluded that close observation and appropriate readjustment of the glycoside dose is warranted when this highly effective drug regimen is initiated. Other drugs may decrease the potassium concentration, yielding a digitalis toxic state: diuretics, laxatives, insulin and salicylates. <sup>14</sup> Dialysis may also predispose to toxicity as well as withdrawal of thyroid extract. <sup>14</sup>

Gastrointestinal manifestations of digitalis overdose (anorexia, nausea, emesis, diarrhea, abdominal pain) occur in at least 50% of the patients and they are often the first indication of toxicity. 16 Neurologic and visual manifestations occur in both acute and chronic toxicity 10,28-31 and may range from headache, fatigue and depression to hallucinations. 32,33 Gynecomastia may develop as a disturbing endocrine complication of digitalis use; however, this condition usually disappears with cessation of the drug. 16

Cardiac manifestations are the most frequent and dangerous sign of digitalis toxicity. It is important to realize that the healthy myocardium and the diseased myocardium respond with different arrhythmias. In an otherwise healthy patient, with an acute overdose of digitalis, ventricular arrhythmias or ectopy are uncommon. 4,10 Instead, the healthy myocardium responds to digitalis excess with the development of A-V conduction disturbances, while the diseased heart frequently responds with ectopic impulse formation particularly from ventricular foci. 4

The earliest ECG changes of digitalization are ST segment sagging, shortening of the QT interval and inversion of the first portion of the T wave. The most characteristic ECG change after therapeutic doses of digitalis is the depression of the ST segment, which is progressive in degree and form and does not necessitate cessation of the drug. <sup>12</sup> In the patient with a previously normal P-R interval who is undergoing digitalis therapy and subsequently develops prolongation

#### Frequency of various digitalis induced arrhythmias<sup>14</sup>

ANALYSIS OF CARDIAC ARRHYTHMIAS

(10 series with a total of 681 patients)

	No of Series	No of A	Arrhythm	as
Ventricular Arrhythmias	470 (71%)			
Ventricular Prematures Bigeminy	9		420	150
Multifocal	4			121
Not Specified	4			79
Other (Frequent, unifocal, occasional, etc.)	3			70
Ventricular Tachycardia	7		50	
A-V Block		194 (29%)		
First Degree	7		87	
Second Degree	10		58	
Wenckebach	3			4
Third Degree	6		37	
Unspecified	2		12	
Atrial Arrhythmias		177 (26%)		
Atrial Fibrillation	9		80	
With Slow Rate	2		50	21
PAT With Block Atrial Prematures	7 4		59 <b>27</b>	
Atrial Flutter	4		11	
		05 (100/)		
SA Arrhythmias Sinus Tachycardia	3	85 (13%)	29	
Sinus Pachycardia Sinus Bradycardia	4		27	
With Nodal Escape	1			11
Sinus Arrest	2		11	
S-A Block	3		7	
Wandering Pacemaker	3		11	
A-V Dissociation	4	65 (9 8%)		
A-V Nodal Arrhythmias		47 (7%)		
Nodal Tachycardia	4		32	
Nodal Rhythm	2		11	
Nodal Prematures	1		4	

of the P-R interval, one should discontinue the drug and resume in smaller doses, after the P-R interval is normal. This is in contrast to the patient with a previously prolonged P-R interval, not due to digitalis, who develops prolongation after digitalis therapy. In this patient, there appears to be no contraindication to the use of therapeutic doses of digitalis when required for the treatment of congestive heart failure.<sup>12</sup>

Ventricular arrhythmias are common in digitalis toxicity and are often the earliest sign of toxicity in the chronic user. Fisch has compiled 10 studies said

to represent digitalis-induced arrhythmias and are reproduced in the accompanying *Table*. Analysis of this table disclosed that of 681 patients, 71% of the patients manifested ventricular arrhythmias of which PCV's and ventricular tachycardia were the most common. A-V conduction disturbances were seen in 29% and various forms of atrial arrhythmias in 26%. The high incidence of atrial fibrillation as found by Fisch and other investigators can be explained by the fact that it was impossible in most instances to determine whether the arrhythmia appeared as a result of digitalis intoxication

or was present before digitalis administration. The true incidence of digitalisinduced atrial fibrillation is much lower. Note that arrhythmias that strongly suggest digitalis intoxication, i.e., paroxysmal atrial tachycardia (PAT) with block, A-V dissociation and A-V nodal tachycardia, comprise a small percentage of the entire group.<sup>14</sup>

Of more help to the clinician has been Fisch's determination of the probability that a specific arrhythmia is due to digitalis. These studies have the advantage of being prospective and having a control group. He demonstrated the high probability that multifocal PVCs, A-V nodal tachycardia, A-V dissociation (other than conventional A-V block), PAT with block and ventricular tachycardia are due to digitalis. The probabilities are 93, 72, 63, 55, and 21%, respectively. When these arrhythmias and those in the Table are accompanied by other clinical evidence of digitalis toxicity, one can assume, for all practical purposes, that they are indeed digitalis-induced,14 and the drug should be discontinued.

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#### Sarcoid Nephropathy: Reversible Cause of Severe Renal Impairment with Steroid Therapy

SISIR K. DHAR, M.D. M. N. YUM, M.D. R. JEEVAN, M.D.

#### Abstract

A case of sarcoidosis presenting with undiagnosed renal failure is described. Gallium 67 scan and renal biopsy led to the diagnosis of the underlying condition. The value of steroid therapy in this condition is discussed.

ARCOIDOSIS is a multisystem disorder characterized by epithelioid cell granuloma with protean clinical and laboratory manifestations. Though calcium nephropathy and granulomatous infiltrate in the kidney are reasonably common, resultant severe renal impairment is rare.<sup>2,4,7,8</sup> Herein we describe a patient who presented with severe renal impairment due to sarcoid nephropathy but responded to steroid therapy with improvement of renal function.

#### Case Report

A 59-year-old white man was admitted to Union Hospital with lower extremities fatigue and approximately 50-pound weight loss of one year's duration. The patient denied any history of night sweats, anorexia, change of bowel habits, fever, or urinary symptoms. Physical examination showed BP 130/70 mm/Hg, pulse 70/min., respirations 14/min., temperature 99°F, and the rest of examination was unremarkable. Initial laboratory data showed complete blood count (CBC): Hgb 12.4 gm/dl, Hct 37% with normal WBC and platelet count. Urinalysis showed: SP.Gr. 1012, 3 + protein, 1 + blood, 0-2 WBC, 4-5 hyaline and granular casts per high power field, SMA 12: serum calcium 12.3mg/dl (N 8.1-10.7mg/dl), BUN 40 mg/dl (N 5.7-26.8), Creatinine 4mg/dl (N .7-1.6). Total protein 7.8gm/dl. 24-hour urine protein 1.3gm, calcium 570mg (N 100-250mg). Creatinine clearance 31mls/ min. Serum protein electrophoresis showed polyclonal gammopathy.

Quantitative immunoglobulin 1gG 1940mg/dl (N 800-1800mg/dl), 1gM 255 mg/dl (N 60-250mg/dl), 1gA 1026mg/dl (N 90-450mg/dl). The following studies

were normal or negative: chest x-ray, 1VP with tomograms, skull and hand x-rays, upper Gl, lower Gl x-rays, computed tomography (CT) of lungs, retroperitoneum, mediastinum, technetium bone scan, serum angiotensin converting enzyme assay, antismooth muscle antibody, antimitochondrial antibody, hepatitis associated antigen, bone marrow histopathology. Gallium 67 scan showed abnormal uptake mediastinal lymph nodes, kidneys, salivary glands. Serum 1.25 (OH<sub>2</sub>)D<sub>3</sub> (1 - 25 - hydroxycholecalciferol) elevated 90 PG/ML (N 37-69), 25 hydroxy vit. D<sub>3</sub> was normal.

The patient was initially treated with intravenous saline solution for hydration and diuresis and subsequently subcutaneous calcitonin with normalization of serum calcium. However, his renal function did not respond to therapy of hypercalcemia. Because of persistent renal abnormality, percutaneous renal biopsy was done. Renal biopsy disclosed normal glomeruli, focal interstitial fibrosis and infiltration of chronic inflammatory cells, and a non-caseating granuloma in the interstitium (Figure). Immunofluorescence and electron microscopy excluded glomerulonephritis. Special stains for acid fast bacilli and fungi were negative. Mediastinal lymph node biopsy showed non-caseating granuloma.

The patient was treated with Prednisone 60mg/day for three months and then gradual reduction of dosage to 10mg on alternate days. The patient's serum calcium remained normal, renal function improved, serum creatinine BUN stabilized at 2mg/dl and 20gm/dl, respectively. Six months later, 24-hour urine protein was 260mg. Creatinine clearance was 67mls/min.

From the Dept. of Medicine, Union Hospital, Terre Haute, Ind., and the Dept. of Pathology, Indiana University Medical Center, Indianapolis.

Correspondence: Sisir K. Dhar, M.D., 615 — 8th Ave., Terre Haute, Ind. 47804.

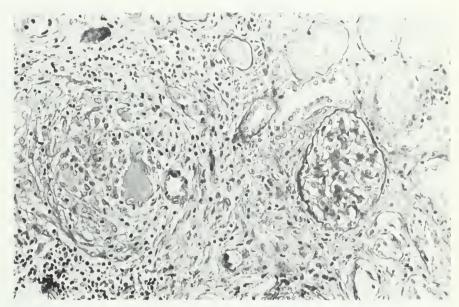
Acknowledgment: J. E. Stephens, M.D., Brazil, Ind., for referring the patient.

#### Discussion

Syndrome of sarcoid nephropathy includes the following: renal insufficiency, hypercalciuria (with nephrolithiasis, obstructive uropathy), accelerated hypertension, renal tubular abnormality (renal glycosuria, renal tubular acidosis, concentration defect), granulomatous infiltration, calcium nephropathy, arteritis, glomerulonephritis, and nephrotic syndrome. 1,7 Sarcoid granulomas have been noted in 15 to 40% of patients with sarcoidosis at autopsy. 4,7 However, renal failure due to granuloma is very rare.

Other causes of granulomatous involvement of kidneys include chronic infection (tuberculosis, leprosy, histoplasmosis), Wegener's granulomatosis, microscopic polyarteritis, Churg-Strauss granulomatosis, drug-induced granuloma, Xanthogranulomatous pyelonephritis and malacoplakia. These causes were excluded in our case by appropriate bacteriologic studies and histologic and clinical features. Moreover, presence of granulomata with nephrocalcinosis in our case suggested sarcoid nephropathy as the etiology of renal failure. Hypercalcemia was initially felt to be the cause of renal failure in our patient; however, normalization of serum calcium did not improve renal function. Other effects of disordered calcium metabolism, including nephrolithiasis and obstructive uropathy, were absent in our patient. As reported before, occurrence of hypercalcemia correlated well with dissemination of sarcoidosis in our patient.

At present it is felt that hypercalcemia in sarcoidosis results from enhanced sensitivity of vit. D. 6.9.10 Recent studies indicate high plasma concentration of 1.25 hydroxy vit. D (1.25 OH<sub>2</sub>D) because increased production or reduced clearance is probably the cause of hypercalcemia. 6.10 In our patient high serum level 1.25 (OH<sub>2</sub>)D level with normal 25 (OH<sub>2</sub>)D supports that hypothesis. Finally, though glomerulonephritis and arteritis have been described in association with sarcoidosis, these were absent



RENAL BIOPSY showing a normal glomerulus and a non-case ating granuloma with multinucleate giant cells. (PAS; x 375)

in our case. It is of interest the gallium scan correlated with activity of disease of kidneys, possibly due to increased uptake by granuloma. With successful treatment, repeat gallium scan did not show further accumulation of radioactive gallium 67. Thus a gallium 67 scan may be of help for follow-up treatment.

As previously reported, rapid and sustained improvement of renal function occurred in our patient with steroid therapy.

Steroid may improve renal function by correcting hypercalcemia, hypercalciuria, and decreasing granulomata formation and interstitial nephritis. Long-term follow-up reports indicate renal impairment recurs with discontinuation of steroid therapy or rapid tapering of steroid therapy. Consequently, close supervision of renal sarcoidosis is required, particularly following steroid therapy.

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#### **OSTEOPOROSIS**

#### A National Institutes of Health Consensus Report Synopsis

FRANK B RAMSEY, M.D. Indianapolis

RIMARY OSTEOPOROSIS is an agerelated disorder characterized by decreased bone mass and by increased susceptibility to fractures in the absence of other recognizable causes of bone loss.

Osteoporosis affects as many as 15 to 20 million individuals in the United States. About 1.3 million fractures attributable to osteoporosis occur annually

This synopsis is based on an N1H consensus development conference conducted in April 1984. Single copies of the complete consensus statement are available from Michael J. Bernstein, Office of Medical Applications of Research, Bldg. 1, Rm. 216, National Institutes of Health, Bethesda, Md. 20205.

in people age 45 and older. At age 90 and above 32% of women and 17% of men suffer a hip fracture, usually due to osteoporosis.

Peak bone mass is reached at about 35 years of age. After the peak, bone mass decreases. This is more pronounced after artificial or natural menopause in women and in the elderly.

Fractures occur in the thoracic and lumbar vertebral bodies, the neck and intertrochanteric regions of the femur, and the distal radius. Fractures may occur during routine activities or as a result of slight trauma.

Diagnosis is made by establishing the presence of osteoporosis and excluding causes of secondary osteoporosis such as osteomalacia, hyperparathyroidism, hyperthyroidism, multiple myeloma, metastatic disease and glucocorticoid excess.

Bone mass declines with age in all people and is related to sex, race, menopause.

and body weight for height. Women are at higher risk than men. Whites are at higher risk than blacks. Underweight women have the disease more often than those overweight. Cigarette smoking and calcium deficiency are additional factors. Prolonged bed rest is associated with osteoporosis and regular exercise aids in prevention.

Estrogen replacement slows bone loss after either artificial or natural menopause.

Prevention and treatment involve increasing the intake of calcium. Carcinoma of the endometrium may be discovered at an early stage and may be cured in almost all cases. Progestogen may be added and probably reduces the risk of uterine carcinoma. Cyclic estrogen therapy should be given to women whose ovaries are removed before age 50, if there are no contraindications.

Exercise and good nutrition are valuable aids.

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#### The ISMA Key Contact System

#### RUTH GATTMAN Elkhart

A LTHOUGH THE Indiana State Medical Association had used a key legislative contact system for several years, it soon learned that the real secret to making the system work effectively was to make the ISMA Auxiliary a part of the program.

The need for legislative action always comes at the most inopportune time. By having a joint effort with a physician and an Auxilian, the chances of one being available to react when needed increases 100%. The goal for having an active, responsive key contact system is to have one physician and one Auxilian designated as a key contact person for each state and federal legislator.

A "key contact" is a person who already knows, or is willing to get to know one U.S. or state legislator on a personal basis—a person who will take the time to know the legislator's background, education, family, hobbies and interests, as you would any new friend. A key contact is someone who will develop a rapport with the legislator and become a contact whose advice and opinions the legislator will seek and respect. In the same way, the key person can contact the legislator when emphasis needs to be given to the good or harmful effects of pending legislation.

A key contact person will take the time to keep up to date on current and proposed legislation that might affect the quality of medical care in Indiana or on the federal level.

Presented at a Legislative Workshop at the Sheraton Meridian Hotel, Indianapolis, Dec. 15, 1983. Mrs. Gattman is a past president of the ISMA Auxiliary.

To be a key contact takes commitment, intelligence and the willingness to take time to do the job right. It may not be for everyone. But for those who do decide to participate, it will provide worthwhile experiences. Key contacts don't change each year; they continue on as long as needed, or until their legislator is defeated or retires. Continuity makes the most effective key contact system.

Each person who agrees will be asked to be a key contact for one state legislator from his or her area. For those who already know their legislator, it will be a simple matter to establish or re-establish a personal relationship. Working with a legislator you've never met will be more difficult at first. Have a friend, another physician or an auxiliary member, or someone the legislator knows, introduce you.

Next, invite the legislator for coffee, or make an appointment to meet with him or her. Do some homework before you meet so that you will be knowledgeable about his past legislative experience and committee assignments. If the legislator is new, discuss the upcoming session of the legislature and what he'd like to accomplish. Offer him the assistance of the ISMA in medical matters, particularly if a medical emergency arises.

When your county medical society has a legislative meeting, invite your legislator to attend as your guest. If the society doesn't have such meetings, suggest they begin. Attend the ISMA legislative reception and be sure to extend an invitation to your legislator to attend. Give him a call and thank him for taking a stand on an issue. Let him know you appreciate the job he is doing.

All of this may seem very basic, and it is, but it works. During the last session of the legislature, a few days before the ISMA's legislative reception, I called on the house WATS line and left a message for the four state representatives from our

area. My message was brief and to the point: "Hope to see you at the ISMA's legislative reception at the Columbia Club, date and time. Signed: Ruth Gattman." Our legislators are members of both political parties. I had been a county vice-chairman and had actively worked for the opponent of one of these legislators. Yet, all of them attended the reception, either alone or with their wife. All thanked me for my interest and taking the time to travel to Indianapolis for this reception. They all appreciated my message and said it was a good reminder to them. Yes, I do know all of these legislators, but you can begin with one. The results will amaze you.

This effort is necessary because, with more and more medically related legislation being enacted by our state legislature, we must become involved on a one-to-one basis. Who knows better than we do what's best, medically, for the citizens of our state?

To be effective key contacts, you must be informed. It is essential that you read the legislative material provided by the ISMA. If you don't understand or agree, give them a call or ask for more information. The *American Medical News* is also an excellent source of information. When you are asked to contact a legislator, you will be given specific information about the legislation. If your legislator asks you a question you can't answer, tell him you'll be happy to get more information for him, and then do it. Call the ISMA and ask them to assist you in following through on this request.

The most effective key contacts are people who help support the candidate in some way during his election campaign and assist him after he's elected. This is not a prerequisite to being a key contact, of course, because the key contact is a legislative, not a political, program.

A good key contact will be alert for vacancies in elective offices and will have

in mind people within the medical community who would be willing to run for office. Should IMPAC (the Indiana Medical Political Action Committee) decide to help your legislator during an election campaign, you will be informed. That's always one of the nicest times to contact a legislator, especially if the money has not been actively solicited by the legislator.

A few years ago a bright, young, conservative businessman soundly defeated a long-standing, liberal congressional leader. His election victory was the result of a great deal of grass-roots support and a small percentage of political action involvement. Physicians and their spouses were involved in the campaign, but none in a key leadership role. IMPAC con-

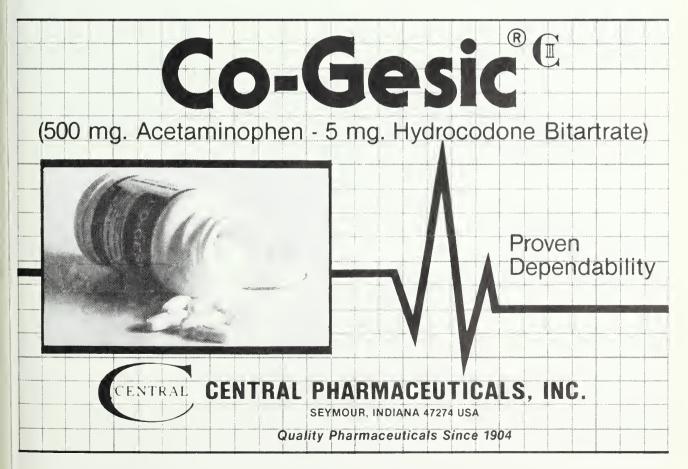
tributed to his campaign, but quite late, at his request.

After the election, a small delegation representing the ISMA and the Auxiliary met with the congressman and later, during a Washington visit, met with him and his staff. He readily admitted he did not know much about medical legislation and could use our help. The AMA office in Washington was contacted and agreed to assist with background information on medical legislation.

We maintained consistent contact by mail, in the district, and in person during the next six to eight months. In effect, a special key contact system was set up to get to know this congressman personally. One-page factsheets on medical legislation were prepared and sent to him by the

ISMA executive director. A good rapport was established, including trust and respect for each other's opinions. Our efforts have been most successful. He was one of the co-sponsors of HR 3722 (the Luken-Lee amendment that provided for a moratorium on FTC actions against the professions). He has been of help on other legislation as well.

Two-way communication is on-going. Every once in a while, a letter arrives with a note attached saying, thought you might like to see this. Yes, it does take time, effort, and some expense to make the key contact system work, but the results are truly worth it. We now have another friend, not a foe, in Washington—and that surely makes our efforts worthwhile.



#### A Tale of Two Revolutions

#### Commentary

RICHARD L. LESHER

President
U.S. Chamber of Commerce

n May 15, 1776, the Virginia Convention instructed its delegates to the Continental Congress, meeting in Philadelphia, to propose independence for the 13 colonies from British rule. Following those instructions, delegate Richard Henry Lee introduced a resolution on June 7 that said, "these United Colonies are and of right ought to be free and independent States." Congress appointed a committee, led by Thomas Jefferson, to prepare the document.

Congress accepted the Declaration of Independence on July 4, 1776. The American Revolution had officially begun. The war against British rule had actually been raging for some time. The Boston Tea Party took place on the night of Dec. 16, 1773. The battles of Lexington and Concord were fought on April 19, 1775. American troops had already captured Fort Ticonderoga and Crown Port.

Yet, of all these dates, we celebrate July 4 as the date of our nation's independence from Britain. Why? 1 suggest that the reason lics in the nature of the American Revolution. It was not simply a war of national independence, not merely a struggle by force of arms. Our revolution was, in its truest sense, a political revolution. It overthrew not only King George, but the very idea of Kings. American patriots left their fields and took up arms, not to change governments, but to change the fundamental relationship between government and the people.

The pitched battles at Trenton and Yorktown were not fought over whose image would appear on our coins, but over the ultimate question of who was to rule. Would the people control their government or would the government control the people?

When the American Revolution ended with the defeat of Cornwallis on Oct. 19, 1781, and the Treaty of Paris on Sept. 3, 1783, the state had lost. The people had won.

Six years later the Constitution was drafted to limit the power of the federal government and enshrine the rights of all men and women.

The American Revolution had succeeded in establishing the principles laid down in the Declaration of Independence where Congress had declared, "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are Life, Liberty and the Pursuit of Happiness."

Thirteen years after the Declaration of Independence, the people of Paris stormed the Bastille and began their revolt against King Louis the Sixteenth. The French Revolution had begun. The American people originally looked on the French Revolution with favor, expecting that it too would bring about a democratic and free society. Sadly, the revolution was soon betrayed as rule by the aristocracy was replaced by the Committee of Public Safety—the agent of the Terror of the guillotine.

The people of France had not won their freedom or respect for their inalienable rights. The orgy of bloodletting had served only to change their masters.

Various factions, dictatorships, and directorates vied for power. Eventually, Napoleon rose from the barracks to name himself counsul for life. And when Napoleon was finally defeated at Waterloo, the monarchy returned.

Had the French revolution succeeded, the history of Europe and the world might have been different and happier. As we survey the various upheavals and coups that have shaken nations since that time, however, we find they have invariably followed the French model and untold misery has been the grim harvest.

The Bolshevik Revolution in 1917 was one such failure. For, despite common misperception, the Communists under Lenin overthrew not the Czar, but the Social Democrats led by Kerensky. Czar Nicolaus had abdicated on March 15, 1917; the communists seized power on Nov. 6 from a democratic government. Russia, like France, had exchanged one despotism for another.

The American Revolution and our Constitution are our heritage. We should be proud and thankful that ours was a successful revolution. By placing shackles on the power of the central government we have built the most prosperous and free society the world has ever known. Yet, the patriots of the revolution gave us not only freedom but a challenge. And that challenge is the duty to preserve the liberties that they fought and died for.

For the struggle for freedom is never over, it must be fought by every generation and the burden falls upon us to defend against any and all encroachments on our liberties and rights as free men and women—both here at home and from the enemies of liberty abroad.

The original American revolutionaries deserve no less from us.

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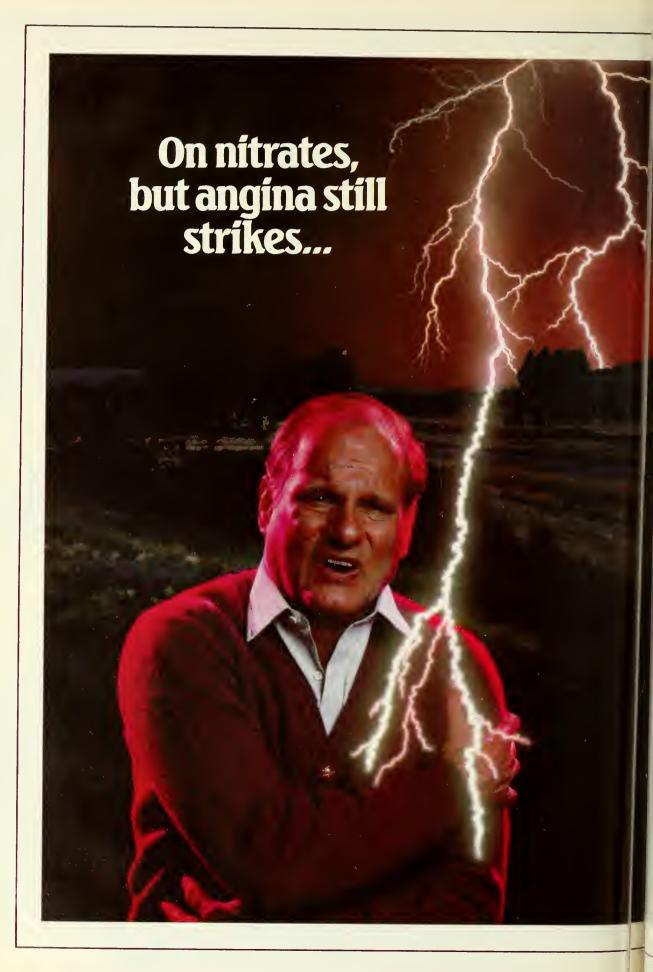
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OF THIS PUBLICATION & ACT



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Cardiovascular contraindications to the use of
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hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome
(if no artificial pacemaker is present)
and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

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Contraindications: Severe left ventricular dysfunction (see Warnings), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. Precautions: ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving bloodpressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use Adverse Reactions: Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. How Supplied: ISOPTIN (verapamil HCI) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982



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## **TRUTH**

When the North Atlantic Treaty Organization was formed in 1949, it was formed for one reason. To stop Soviet aggression in Europe.

### TRUTH

The Warsaw Pact's conventional fighting capabilities far exceed that of European NATO forces.

### TRUTH

In order to maintain peace and freedom in Europe, NATO has effectively maintained a policy of deterrence with the Soviet Union.

### TRUTH

The past 35 years of peace have been one of the longest periods of European peace in recorded history.

### TRUTH

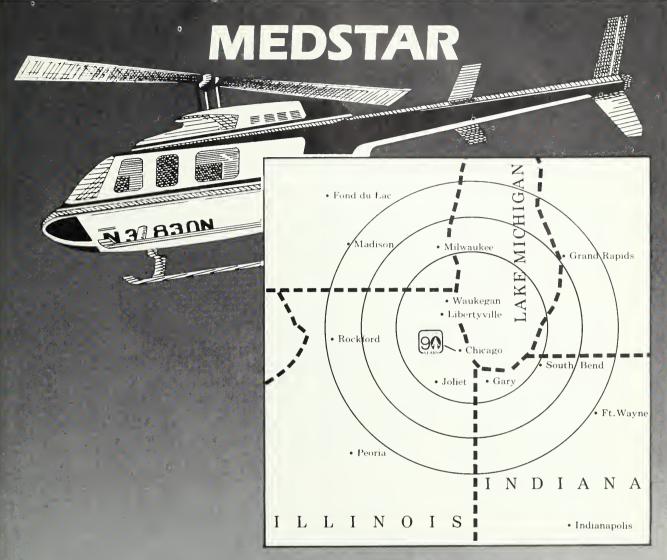
The Soviets will not risk war. Unless they are sure they can win.

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#### EDITORIALS

#### The Give and Take of Patent Extension

Most new drugs are discovered by large research-oriented pharmaceutical firms. Such discoveries are patented as soon as the parent company has demonstrated that the new substance is both safe and effective.

However, a prolonged period of clinical research is then necessary to demonstrate to federal authorities that the drug exhibits the same characteristics when tested clinically in diagnosing or treating large numbers of volunteer patients.

When the new drug is approved for marketing, a significant number of years of its patent life have been spent in the important and sometimes time-consuming clinical investigation.

The cost of discovering the drug and the expense of its testing under clinical conditions is usually high. Since pharmaceutical manufacturers investigate many substances that eventually prove not to be useful, the discovery cost of most drugs admitted to the prescription market amounts to very large sums of money. One function of the patent is to allow the discoverer to recover the cost of research and promotion.

Another element in the discovery of new drugs is that, as the period of clinical research becomes longer and longer, the life of the patent for practical purposes becomes shorter and shorter.

The monopoly period, as conferred by the patent, is most important in the recovery of the immense sum of money now necessary in the research, discovery, clinical research and promotion of new entities. In fact, unless the cost of inventing and bringing a new drug to market is recoverable, no pharmaceutical manufacturer would be able to finance research for other new, badly needed drugs.

For several years Congress has considered a bill that would extend the life of the patent by the length of time required for clinical investigation prior to approval for marketing. The bill, as written, applies to all patents, but would be of special significance in the case of pharmaceutical substances.

The bill has gone through an amazing amount of debate and controversy, mostly from the research-oriented drug makers

on one hand and the generic drug companies on the other. Those who manufacture generic preparations after patents have expired would like to make the patent life shorter. Those who discover new drugs by their own research are in favor of a patent life which would allow various compromises have created conditions which would make the legislation either impossible or next to impossible to administer.

The fair and equitable provisions of the bill for the preservation of new-drug research should prevail. The generic drug

#### Congress Approves Drug Patent Extension

The Senate, by voice vote on Sept. 12, passed and sent to the President S. 1538, Drug Price Competition and Patent Term Restoration Act of 1984. The House, by a vote of 362-0, had approved the bill on Sept. 6.

The legislation would extend the patent term of brand-name drugs for up to five years (with a patent life cap of 14 years) to compensate manufacturers for the time required to conduct product testing and to secure FDA approval of the drug. This provision of the bill is intended to provide new incentives for brand-name phar-

maceutical companies to increase their expenditures for research and development.

The bill would also permit drug manufacturers to use an abbreviated new drug application (ANDA) for approval of generic versions of brand-name drugs approved after 1962. Currently, the FDA can require the manufacturers of generic copies of drugs approved after 1962 to conduct additional clinical tests even though the FDA has already determined that the brand-name drug is safe and effective. This provision of the bill is expected to result in reduced drug costs due to the greater availability of cheaper generic drugs.—AMA Legislative Roundup, Sept. 14, 1984.

each discoverer to recover the expense of producing the new drug.

As a matter of fact, the generic firms should also favor a patent life sufficient to replace research funds. The system, as it functions now, will soon dry up all research funds and there will be very few new drugs, either for the research companies or for those who make generic preparations.

The differences, as you might expect, have been compromised and compromised. The bill is now titled the "Drug Price Competition and Patent Term Restoration Act of 1984." The compromises have developed a few additional groups of supporters and antagonists. A small group of the research-oriented firms has separated and may end up as a part of the generic group.

The bright spot in the long life of the bill is that it has not disappeared. It has, in one form or another, survived for consideration each year. It will, no doubt, be on the calendar in 1985.

The major obstacle now is that several bureaus of the government which would have jurisdiction over the bill if it becomes law have testified that the makers should be content to settle for a system which will resupply research funds for new-drug discovery. Lengthening the patent life by the length of time required for governmental approval will delay, by a few years, the advent of patent-expired drugs, but will help to insure that new drugs will keep coming. Otherwise, some day there may not be any new ones.



"Going through the books, I find that the first \$7.00 of your fee goes to pay the staff to take care of the government forms."

#### It's Time to Call Rationing by Its Right Name

It's time for people in the federal government, in business and industry and all of the others who are busy trying to restructure the medical and health care field to stop calling their goal "cost containment" and start calling it what it is: rationing of care, restrictions on services and reductions in payment for the care people need.

Physicians and the rest of the health care field are doing everything they can to control the cost of care, and consequently reduce necessary charges for it. That is cost containment.

Meanwhile, private companies are cutting back their insurance programs, to pay less; the government is doing the same thing; both without considering what it costs to provide care and concentrating only on the out-of-pocket amount they pay for it.

DRGs are an example. They have nothing to do with the cost of providing hospital care to patients. They only limit the amount the government will pay for that care.

Another example is the federal government's new moves in Medicare. But this time, we're fighting back.

The Medicare fee freeze and "participation" agreements do not contain cost. They reduce payments for the care Medicare beneficiaries should receive. In the process, they violate patients' rights to choose their own physicians; they abrogate the government's contract with its Medicare beneficiaries which guarantees equal treatment of all of them; and they blatantly discriminate economically against one segment of the population.

The American Medical Association is filing suit in federal court to have those changes declared null and void and to prevent the Department of HHS from enforcing them.

While we wait for a judgment from the court, we have the responsibility of continuing to care for our Medicare patients. We have to do it the best way we can—as we always have done—by considering not only their medical needs, but their financial situation. Most of us can do that, even at a loss.

But if the government wins the case, or as the new law goes into effect before

the case is settled, it is possible that some of us will find it impossible to continue serving Medicare patients. Not many, hopefully, but a few might have to withdraw from the program.

If that happens, let's be sure our patients understand exactly what has caused it. Let them know that it is their government that has refused to keep the promises it made to Medicare beneficiaries. Let them know that it is their government that is rationing the care they can receive, not their physicians.

Let's not permit the government to make us look like the bad guys, when it is the government itself that has decided it will no longer pay for the kind or amount of care Medicare patients need.—Contributed by the American Medical Association

#### Office Diagnostics

Boehringer Mannheim Diagnostics, one of the major subsidiaries of Boehringer Mannheim Corporation, was established in Indianapolis in 1964.

It comprises four divisions: Physician Laboratory Products, Boehringer Mannheim Diagnostics for hospital and lab equipment, Diabetes and Urinalysis Products, and Bio-Chemicals. It is a pioneer in wet and dry chemistry analyzers, and recently introduced the revoluntionary new dry chemistry analyzer, the Reflotron.

Laboratory equipment for physicians' offices is now especially important because of the advantage of office diagnostics and the lessening of such diagnostic tests in a hospital setting.

#### English as She Is Spoke'

Letter to the Editor

Sir:

It is a long time since you have heard from me, but I have a farmer friend who frequently makes a remark that lays the English language wide open. The other day he said, casually, "You know, my dog, Hilda, reminds me of my wife, Matilda: On some days she smells worse than others."

Now, as a medical man you might be interested in the physiology of this but to me it is an example of the possible treachery residing in the King's English. In this case, does "others" refer to dogs, days, or wives?

It is a pity we no longer have the services of J. W. Riley to write us Hoosiers a poem on it. I await your reply with interest.—Alister Caobhain, R.R. 13, Box 31.

#### The Rush to Misinform

Misinformation to the public is harmful and very difficult to correct. A recent sensational rehash of an old and discredited piece of "research" has been picked up by at least two of the national television networks. It is natural for newsmen to seize on some "scientific" release which goes against conventional wisdom.

Such was the case of the report in *Science* magazine which announced that hypertension was and is associated with deficiencies in the diet, mostly in the low intake of calcium and other nutrients, and that the intake of sodium did not cause hypertension and might be one of the essentials of diet that would reduce high blood pressure.

The newscasts protected the networks by reporting that the "new release" was encountering opposition from some physicians. However, millions of hypertensives heard that salt was not the villain.

How many of those listening have had their hypertension regimens upset is strictly conjectural, but curing the salt habit is difficult and many a patient is now enjoying an excess of table salt, much to his or her disadvantage.

Dr. William T. Friedewald, head of the National Heart, Lung and Blood Institute's division of epidemiology and clinical applications is quoted as saying: "There are enough studies to fill a room, showing a definite relationship between high salt intake and increased blood pressure."



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Tom Martens Director, Health Insurance Administration Indiana State Medical Association 3935 North Meridian Street Indianapolis, Indiana 46208 (317) 926-4424 1-800-382-1721



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#### CME QUIZ.

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: Indiana University School of Medicine, CME Division, Fesler Hall 224, 1120 South Dr., Indianapolis 46223.

#### **Sexually Transmitted Diseases**

CONTINUED FROM PAGES 857-862

- 1. The proper management of a woman who has had sexual relations with a man known to have gonorrhea is:
  - a. perform examination, obtain cultures, and await culture results before instituting treatment.
  - treat presumptively; examination unnecessary if patient is asymptomatic.
  - perform examination, but do not obtain culture; treat presumptively.
  - examine for salpingitis, obtain cultures, and treat presumptively without waiting for culture results.
- In a patient with a history of poor compliance and known to have uncomplicated gonorrhea, which of the following treatment regimens is most appropriate:
  - 3.5g of ampicillin plus 1g of probenicid orally as a single treatment.
  - Tetracycline 500mg orally QID for seven days.
  - 3.5g of ampicillin plus 1g of probenicid orally as a single dose followed by tetracycline 500mg QID for seven days.

- d. Spectinomycin 2g 1M as a single treatment.
- A mucopurulent discharge from the cervical os is most often associated with:
  - a. gardnerella vaginalis.
  - b. C. trachomatis or N. gonorrhoeae.
  - Herpes simplex.
  - d. Trichomonas vaginalis.
- 4. Chronic subacute salpingitis diagnosed during an infertility work-up is most likely caused by:
  - Neisseria gonorrhoeae.
  - Chlamydia trachomatis.
  - anaerobes.
  - Gram-negative aerobic rods (e.g., E. coli)
- 5. Each of the following is true regarding genital herpes except:
  - a. Acyclovir is more likely to be effective in recurrent disease than in primary.
  - systemic manifestations are frequent in primary disease, but not with recurrent disease.
  - c. it is a common cause of inguinal

- adenopathy in young adults.
- d. the duration of symptoms is less in recurrent disease than in primary disease.
- 6. Patients with genital herpes are:
  - a. potentially infectious at any time, but more likely to be so when they have active lesions.
  - only infectious when they have active lesions.
  - highly infectious all of the time.
  - only infectious if they have wet ulcers.
- A pregnant woman with a history of genital herpes should be:
  - a. advised to have an abortion during the first trimester.
  - followed closely during pregnancy and delivered by cesarean section if she has active lesions or positive viral cultures during the last week of pregnancy.
  - delivered by cesarean section irrespective of lesions or culture results.
  - d. delivered vaginally even if the lesions are present on the endocervix.
- The VDRL (or RPR) is essentially always positive in:
  - primary syphilis.
  - b. secondary syphilis.
  - tertiary syphilis. С.
  - late latent syphilis.

CONTINUED ON PAGE 921

#### **OCTOBER CME QUIZ Answers**

Following are the answers to the CME quiz that appeared in the October 1984 issue: "Child Safety Seats: Proper Use and Selection," by Marilyn J. Bull, M.D., et al. 1. e 6. e

- 2. f
- 7. b 8. b
- 3. e 4. b
  - 9. e
- 5. b 10 4-1-6-5-2-7-3

Answer sheet for Quiz: (Sexually Transmitted Diseases)

1. a b c d 6. a b c d 2. a b c d 7. a b c d 3. a b c d 8. a b c d 4. a b c d 9. a b c d 5. a b c d 10. a b c d

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of INDIANA MEDICINE for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for this month's quiz, send your completed, signed application before Dec. 10, 1984 to the address appearing at the top of this page.

# Look-Alike and Sound-Alike Drug Names

BENJAMIN TEPLITSKY, R. PH. Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions. Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors.

-38 EAST HIGH ST

Category: Brand Name: Generic Name: Dosage Forms:

Category: Brand Name: Generic Name; Dosage Forms: PREDNISONE

Glucocorticoid many brands Prednisone Tablets, Syrup

SPARINE Antipsychotic Sparine, Wyeth Promazine HCl Tablets, Syrup,

Injection, Concentrate

PREDNISOLONE

Glucocorticoid many brands Prednisolone Tablets, Injection

STERANE
Glucocorticoid
Sterane, Pfipharmecs
Prednisolone
Tablets, Injection

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#### AUXILIARY REPORT

Judy Koontz (Mrs. James A.) President, ISMA Auxiliary

#### A Time for Thanksgiving

To be a physician's spouse demands independence and a strong will. Have YOU noticed? They experience pressures and demands on their time which are basically different from those of their non-medically oriented neighbors and friends. Have YOU noticed? Often they must be both mother and father to your children. Many times they carry the responsibilities of being home and financial managers, auto repairmen, electricians, and plumbers! Have YOU noticed?

Medical auxilians are special people. They are unique, well educated, intelligent, talented, and very, very capable of wearing their many, many different hats. And—do YOU know what?? They do it all for YOU! They have so much to offer to you, to your family, to themselves, and to your community.

Auxilians are spouses of physicians who care about and share the joys and the sorrows of medical families. The Auxiliary has two basic purposes. These are to provide an opportunity for members to share interests and goals with others who have the same concerns; and to help to assure quality health programs and care for all people. The Auxiliary is the only organization to which your spouse can belong that will provide the needed support for all the special situations that can arise in the medical family.

Through Auxiliary membership, your spouse can be a part of the concerns which are so important to you. And yet, she (he) can expand and can use talents to her (his) own purposes.

#### Membership

It is time for a change of seasons that I as ng will soon be here. Won't

you make it a point to thank your spouse for her (his) involvement in the Medical Auxiliary? If she (he) is not a member, won't you encourage the idea? How about calling a joint dinner meeting of the society and auxiliary? A special invitation to the non-member and spouse in your community would be super. A current medical family could even host them by paying for their dinner and by bringing them to the get-together. Just think how much this could increase membership by making that personal, one-on-one contact! I feel very strongly that the physicians' attitudes, support, and concerns for the Auxiliary's goals and purposes greatly influence the Auxiliary's success. I would like to encourage you, the county medical societies, to encourage your auxiliaries to become involved in medically oriented community activities in your area.

Would you physicians be so kind as to share some of the programs in which your auxilians are involved? Our readers want to know what they are doing. Sometimes they are too bashful and reluctant to tell their success stories. You can send the information to Marty Badger, Managing Editor, or to me. We will see that the Auxiliary news is published on the Auxiliary Page of this publication as space allows.

Happy Thanksgiving to each of you and your special MEDICAL FAMILY from the ISMA Auxiliary!

#### Leadership Conference

On Sept. 25, over 60 Indiana medical auxilians participated in the Leadership Conference held at the ISMA Headquarters in Indianapolis. This was an all-day meeting geared toward leadership train-

ing for county officers and chairmen. We truly appreciate and thank you for the use of your facilities for this purpose.

Topics covered at the meeting included information on AMA-ERF, Health Projects, Legislation, and Membership.

Special guests and speakers were there and added to the success story. Mrs. Ann Lohmuller, president, and Mrs. Rhonda Meding, board member, of the Indianapolis Medical Students' Spouses' Group were special guests of the ISMA Auxiliary for the day. Mrs. Betty Szewczyk, AMA Auxiliary regional vice president, brought greetings from the AMA-A and spoke on membership. Mr. Donald Foy, ISMA executive director, brought best wishes from the ISMA and delivered timely information from the legislative arena-specificially information concerning the "participating" and "non-participating" decisions as required by the DEFICIT REDUCTION ACT OF 1984; and the second Medicare lawsuit concerning the issue. Mrs. Anne Schuster gave an update on PROJECT MEDVOTE.

The afternoon was spent in break-out sessions with our area vice presidents acting as co-ordinators. This was a time of participation for the county members. It was a time of sharing experiences, ideas, questions and answers.

The "FAMILY WEEKEND AT THE INDIANAPOLIS RADISSON HOTEL" door prize was donated by the Hotel and was won by Mrs. Marla Keppler of Grant County. Congratulations to Dr. and Mrs. Keppler are in order!

The Auxiliary would like to express our appreciation to all of the speakers, members and guests who attended and participated.

# BALANCED CALCIUM CHANNEL BLOCKADE!



#### Low incidence of side effects

CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

\*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

#### References

- Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. <u>Am J Cardiol</u> 49:560-566, 1982.
- 2 Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

#### Reduces angina attack frequency\*

42% to 46% decrease reported in multicenter study.

#### Increases exercise tolerance\*

In Bruce exercise test, control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes (P<.005).

#### CARDIZEM

(diltiazem HCl)

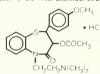
THE BALANCED
CALCIUM CHANNEL BLOCKER

#### PROFESSIONAL USE INFORMATION



DESCRIPTION

CARDIZEM\* (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepir-4(5H)one,3-lacetyloxy) -5-[2-(dimethylaminojethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Oiltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform It has a molecular weight of 450.98. Each tablet of CAROIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

#### CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CAROIZEM is believed

Angina Due to Coronary Artery Spasm: CAROIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CAROIZEM.
 Exertional Angina CAROIZEM has been shown to produce.

increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Oiltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH

interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise testsatice and induces I am I blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of dilitatem and hots bleeds. Rectaes the state of the s of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

of slightly reduced by distraction.

Intravenous diffrazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltrazem significantly prolongs sinus

cycle length (up to 50% in some cases).

Chronic oral administration of CAROIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

degree AV block in a group of 959 chronically treated patients. 
Pharmacokinetics and Metabolism. Dilitazem is absorbed 
from the tablet formulation to about 80% of a reference capsule and 
is subject to an extensive first-pass offect, giving an absolute 
bloavailability (compared to intravenous osing) of about 40%. CAROIZEM 
undergoes extensive hepatic metabolism in which 2% to 4% of the 
unchanged drug appears in the urine. In vitro binding studies show 
CARDIZEM is 70% to 80% bound to plasma proteins. Competitive 
ligand binding studies have also shown CARDIZEM binding is not 
altered by the appearity to expend the proteins. altered by therapeutic concentrations of digoxin, hydrochlorothizatie, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CAROIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Oesacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

#### INDICATIONS AND USAGE

Angina Pectoris Due to Coronary Artery Spasm. CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CAROIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

Chronic Stable Angina (Classic Effort-Associated Angina).

CAROIZEM is indicated in the management of chronic stable angina. CAROIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance. There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this

combination in patients with impaired ventricular function or conduction abnormalities

#### CONTRAINDICATIONS

CAROIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

#### WARNINGS

 Cardlac Conduction. CAROIZEM prolongs AV node refrac-tory periods without significantly prolonging sinus node recov-ery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly) in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of AV DICK (SIX OF 1243 patients for 0.48%). Concomitant use of dilutazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of dilitazem.

Congestive Heart Fallure. Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic

induciple elect in himans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.

**Hypotension.** Oecreases in blood pressure associated with CAROIZEM therapy may occasionally result in symptomatic

 A Acute Hepatic Injury. In rare instances, patients receiving CAROIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. See PRECAUTIONS and ADVERSE REACTIONS.

#### **PRECAUTIONS**

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In sub-acute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage, in special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued in dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CAROIZEM. (See WARNINGS

Controlled and uncontrolled domestic studies suggest that con-comitant use of CAROIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times. the human dose or greater.
There are no well-controlled studies in pregnant women; therefore

use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CAROIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation

Pediatric Use. Safety and effectiveness in children have not been established

#### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CAROIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CAROIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%)

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3% asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular Nervous System: Flushing, arrhythmia, hypotension, bradycar dia, palpitations, congestive heart lailure

Gastrointestinal

Paresthesia, nervousness, somnolence tremor, insomnia, hallucinations, and amnesia Constipation, dyspepsia, diarrhea, vomiting mild elevations of alkaline phosphatase, SGO

SGPT, and LOH Pruritus, petechiae, urticaria, photosensitivity

Dermatologic: Other Polyuria, nocturia

The following additional experiences have been noted. A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CAROIZEM.

The following postmarketing events have been reported infrequently in patients receiving CAROIZEM erythema multiforme, legitopenia, and extreme elevations of alkaline phosphatases, SCO SGPT, LOH, and CPK. However, a definitive cause and effect between these events and CAROIZEM therapy is yet to be established

#### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited Single oral doses of 300 mg of CAROIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerate response, appropriate supportive measures should be employed addition to gastric lavage. The following measures may be considered

Bradycardia

Block

Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously Treat as for bradycardia above. Fixed high-degree AV block should be treated with car-

High-Oegree AV

diac pacing.
Administer inotropic agents (isoprotereno Cardiac Failure

Hypotension

dopamine, or dobutamine) and digretics Vasopressors (eg. dopamine or levartereno bitartrate)

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating

physician. The oral/LD $_{50}$ 's in mice and rats range from 415 to 740 mg/ $^{4}$ g and from 560 to 810 mg/ $^{4}$ g, respectively. The intravenous LO $_{50}$  Sm these species were 60 and 38 mg/ $^{4}$ g, respectively. The oral LD $_{50}$  Sm dogs is considered to be in excess of 50 mg/ $^{4}$ g, while lethality was seen in monkeys at 360 mg/ $^{4}$ g. The toxic dose in man is not known but blood levels in excess of 800 ng/ $^{4}$ ml have not been associated with breights. with toxicity.

#### DOSAGE AND ADMINISTRATION

Exertional Anglina Pectoris Due to Atheroscierotic Comnary Artery Disease or Anglina Pectoris at Rest Due to Comnary Artery Spasm. Dosage must be adjusted to each patients 
needs. Starting with 30 mg lour times daily, before meals and a 
bedtime, dosage should be increased gradually (given in divided 
doses three or four times daily) at one- to two-day intervals until 
optimum response is obtained Although individual patients may 
respond to any dosage level, the average optimum dosage range 
appears to be 180 to 240 mg/day There are no available data concerning dosage requirements in patients with impaired renal or hegatic 
function if the drum must be used in such patients tirration should be function. If the drug must be used in such patients, titration should be carried out with particular caution.

arried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1 Sublingual NTG may be taken as required to abort acute anginal attacks during CAROIZEM therapy.

2 Prophylactic Nitrate Therapy—CAROIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

3. Beta-blockers. (See WARNINGS and PRECAUTIONS.)

#### HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Oose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CAROIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Oose Identification Paks of 100 (NDC 0088-1772-47). Each yellow tablet is engraved with MARION on one side and 1772 on the other Issued 4/1/84

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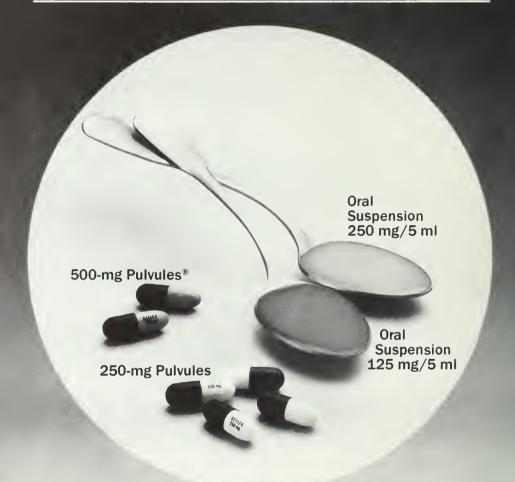
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#### BOOK REVIEWS.

#### **Textbook of Critical Care**

By W. C. Shoemaker, M.D., W. L. Thompson, M.D., Ph.D., and P. R. Holbrook, M.D., Copyright 1984, W. B. Saunders Co., Philadelphia. 1,063 pages, illustrated, \$75.

This is an interesting and wellorganized book which should be useful to all physicians who provide direct care to patients regardless of specialty. It very definitely is not written in cook book style, although needed information is easily found. Nearly 100 co-authors have made contributions to the text. The 123 chapters have been grouped under the headings-Resuscitation and Immediate Care; Monitoring; Ventilation; Cardiovascular; Infections; Visceral Dysfunction; Hematology-Immunology-Oncology; Central Nervous System; Trauma; Therapeutics; Psychosocial Crises; Organization.

As much space is devoted to physiology and pathogenesis as to the "how to" aspects of treatment of the special critical state being considered.

Critical care units, practically nonexistent 25 years ago, are now universally present in hospitals. Given the present preoccupation with the cost of medical care by government and private insurer alike, a shift in hospital bed occupancy is discernable and is likely to continue. Non-critical but necessary patient care is being carried on more and more in homes by family, visiting nurses and hospice personnel. Hospital bed occupancy is shifting very definitely to severely ill patients, with a corresponding shrinkage in patients admitted for diagnostic work-ups on other non-emergency conditions. All physicians need to recognize when critical care is required and to be able to provide, at least, a part of it, without turning patients over entirely to critical care specialists.

As an example of how the various topics are dealt with, the section on "Infections" might be considered. Patients in the critical care unit are at special risk for a variety of reasons. Their ordinary defense mechanisms may be impaired for a variety of reasons—poor immunologic response because of anemia and pancytopenia; bacterial toxins, blood loss; poor nutrition; impaired clearance of secretions from the respiratory tract; poor

circulation to extremities and lungs; prolonged use of urinary catheters; prolonged use of parenteral infusion; infected respiratory assist devices, immobility because of trauma; contamination of surgical wounds; ruptured viscus; infections carried by physicians and hospital personnel; and others. Of course, all of these special risks are present outside intensive care units also. After discussing the various diagnostic procedures, the authors point out the necessity for correction of these factors if at all possible, because this is usually as important, if not more important, than choosing and carrying out specific anti-microbic therapy. The specifics in choosing and administering the latter are well presented.

This book should take its place in the indispensable reference shelf of hospital and physician office libraries. Once one becomes acquainted with what it has to offer, my guess is that it will be used more than the thick medical and surgical texts which must of necessity give comprehensive coverage of all the morbid conditions, acute and chronic, which the practicing physician may encounter. As its title implies, the book presents the background needed for an understanding of why the patient became critically ill and the reasons for proceeding in a logical way to combat the given pathologic condition. It is highly recommended.

Paul S. Rhoads, M.D.
Richmond
Internal Medicine

#### Noninvasive Diagnosis of Vascular Disease

Edited by F. B. Hershey, R. W. Barnes and D. S. Sumner. Copyright 1984, Appleton Davies, Inc., Pasadena, Calif. 371 pages, \$52.50.

This timely, clear, concise exposé of the expanding field of noninvasive vascular diagnosis will prove valuable to the vascular technologist, as well as the vascular surgeon.

Carotid occlusive disease is presented in great detail: Discussions of pathophysiology and anatomy, as well as the use of oculoplethysmography, phonoangiography, periorbital diagnostic techniques, Doppler spectrum analysis, ultrasonic arteriography, and real time bmode imaging are included. Technical details regarding how to perform the test are outlined, although some chapters do not explain enough basics for the novice technician.

Topics in lower extremity evaluation include basic hemodynamics and anatomical considerations of segmental leg pressures. Of note was the coverage of the continuing controversy over inaccurate high thigh pressures, and the dilemmas they present. The discussion of toe versus ankle pressures for amputation selection will be warmly received. Bypass graft evaluation, and surgical re-exploration protocols are given. Briefly covered are PVR and DSA use for the future.

Venous disease assessment and diagnosis, using direct Doppler and plethysmography are nicely discussed. Techniques, positioning, and accuracy are all presented. Isotope scanning, strain gauge, and volume plethysmography are also discussed, along with diagnostic criteria and indications for treatment.

Gary Cook, PAC Alan T. Marty, M.D. Evansville

#### The Low-Fat, Low-Cholesterol Diet

By C. Y. Bond, R.D., et al. Third edition. Copyright 1984, Doubleday & Co., Inc., New York. 512 pages, hardcover, \$17.95.

This volume represents a new, revised edition of an authoritative text first published in 1951. Its scientific basis rests on research carried out at various divisions of the University of California. The second edition of the text in 1971, in addition to restricting saturated fats and cholesterol, introduced polyunsaturated fats. This edition presents a nutritional program that meets the National Research Council's recommended daily dietary allowances for optimal health. The menus presented, in addition to being low in saturated fats, low in cholesterol, and moderate in polyunsaturated fats, are high in fiber and low in sugar, while de-emphasizing the use of excessive salt. Sample chapter titles help define the scope of the book: "What Foods to Use and Not to Use," "Two Weeks of Sample Menus for the Low Saturated Fat, Low Cholesterol Diet,'

"About Changing Food Habits,"
"Dietary Carbohydrate and Fiber,"
"How to Restrict the Sodium on a Low
Saturated Fat, Low Cholesterol Diet."

Numerous chapters deal with specific food types. Various therapeutic diets are described. An important chapter toward the end of the book deals with nutritional science. Low saturated fat, low cholesterol food groups and their average servings are described. Finally, various helpful food tables and charts, a recipe index, and a general index conclude the book. The 500-odd pages of the text, which well reflect the expertise of its multiple authors, present an enormous amount of practical information for the achievement of a rational dietary. It can be enthusiastically recommended for physicians and other health professionals, as well as for the general reading public.

> W. D. Snively Jr., M.D. Evansville Internal Medicine

#### Handbook of Psychosocial Nursing Care

By Carol R. Kneisl and Holly S. Wilson. Copyright 1984, Addison-Wesley Publishing Co., Menlo Park, Calif. 398 pages, \$13.95.

This handbook condenses a very broad topic into a well organized, concise, and compact little book. The outline format, the alphabetical arrangement, and numerous tables render the book a practical, handy reference for both a busy practice or a personal library. It includes four appendices with information on important adjunct topics: ANA standards, psychotropic drugs, communication skills, and the DSM-III classification system. Tables are listed in two places, front and back, and less than five documented references are given throughout. The use of "teaspoon" as a unit of measure (p. 89) is deemed inappropriate.

Perhaps the most desirable and unique contribution of the book is the authors' attempt to add within the outline format, the subdivisions of "assessment" and "nursing intervention." However, here a major flaw occurs: Consistency in sentence structure and nursing process terminology are absent. Content under nursing intervention is given in the nar-

rative or under a variety of headings such as "goals," "objectives," "plans," and "steps." For the "audience" specified, namely "practicing nurses who learned . . . earlier in their careers. . . . students and new graduates" (p. vi) the consistency of generally accepted terminology would have been helpful.

In view of the efforts in nursing to establish consistency in language and nursing diagnoses, this handbook might have been an invaluable asset in that direction had the authors been consistent and persistent in using the nursing process for more than 40 selected "major psychosocial client problems." By incorporating content under nursing process categories, the size of the book need not have been compromised. Nevertheless, the book can serve its intended audience well by bringing a wealth of much neglected psychosocial content to everyday nursing care.

Erica Janzen School of Nursing University of Evansville

#### Lupus: The Body Against Itself

By Sheldon P. Blau, M.D. and Dodi Schultz, revised edition. Copyright 1977 and 1984, Doubleday & Co., Inc., New York. 136 pages, hardcover, \$12.95.

The discussion is concerned with systemic lupus and is divided into three parts: Part One—The Puzzle; Part Two—The Clues, and Part Three—Coping.

Not every book I have reviewed for IN-DIANA MEDICINE has seemed worth the trouble, but this one is. Although it is written as a collaboration of doctor of medicine and journalist (with the latter obviously doing the lion's share of the writing) it lacks the "gimmicks" found in most such books and while it should be an eye-opener for most laymen it is well worth the time of a physician. I feel that any doctor, regardless of speciality, who will take the time to peruse a chapter or two will end up reading it all.

Lupus erythematosus has long been a conundrum within an enigma wrapped in a mystery, but in the past decade discoveries have been made as to where the wrapping may be peeled off so that we can peek within. Let me make one quote from the book (p. 8): . . . . "But lupus is the prototype, the classic and confounding example of what is perhaps the most perplexing puzzle in medicine, not excluding the aberrant cell proliferation of the cancers: the body actively, viciously mobilized against itself." Surely this statement should help the layman understand a bit better the nature of the autoimmune disorders.

The book was obviously written primarily for lay readers, but the physician engaged in clinical practice will gain from it some valuable insights into ways of explaining scientific viewpoints to the ordinary citizen.

A. W. Cavins, M.D. Terre Haute Gynecology

**Thieme-Stratton** announces four new books:

The Diagnosis of Multiple Sclerosis, edited by Charles M. Poser, M.D., lecturer on neurology, Harvard Medical School. The contributors have incorporated approriate laboratory tests, pertinent clinical examinations and the most recent research and advancements. The book is written for internists, neurologists and pediatricians. 253 pages, 67 illustrations, hardcover, \$31.50.

Cystic Fibrosis, edited by Lynn M. Taussig of Arizona Health Sciences Center, Tucson. The book, intended for pulmonologists, pediatricians, family practitioners and internists, discusses the diagnosis and treatment of the disease in children and adults. 512 pages, 97 illustrations, hardcover, \$48.50.

Hematologic Manifestations of Childhood Diseases, by Andre D. Lascari, M.D., Medical College of Pennsylvania. It is written for pediatricians, pediatric hematologists, oncologists, pathologists and family practitioners. The volume is organized by systemic diseases. References are given to diseases that also occur in adults. 480 pages, hardcover, \$45.

Neurology: The Physician's Guide, edited by Robert G. Feldman, M.D., Boston University School of Medicine. The book is a guide to the diagnosis and treatment of common neurologic problems, written for the primary physician. 288 pages, 31 illustrations, softcover, \$29.



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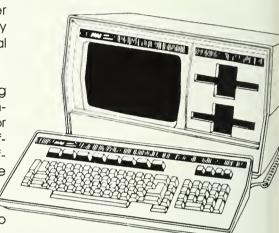
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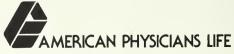
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#### DEWS NOTES.

#### **Easter Seal Catalogs**

The National Easter Seal Society has just produced two mini catalogs of lowcost or free publications concerning disabilities and rehabilitation.

One, "Publications for Parents & Families" (A-316), lists 36 booklets and brochures to assist in understanding and helping family members who have speech disorders, hearing difficulties, learning disabilities, and other disabling conditions. Additional publications deal with attitudes, prevention, and the rehabilitation process.

The other mini catalog, "Publications for Persons Who Have Disabilities and their Friends" (A-317), is targeted to adults and teens with disabilities resulting from stroke, laryngectomy and other disorders. In addition to increasing an understanding of disabling conditions, the pamphlets and brochures are helpful in increasing awareness of the potential abilities of those who have them.

Single copies of either or both catalogs are available free in response to requests accompanied by a self-addressed, stamped, business-size envelope. Requests should be directed to the National Easter Seal Society, 2023 W. Odgen Avenue, Chicago 60612.

#### Hemophilia Fellowships

Applications are now being accepted for the Judith Graham Pool Postgraduate Research Fellowships in hemophilia. The deadline for submission is Jan. 1, 1985.

The grants are for up to \$20,000 for clinical or basic research in the areas of biochemical, genetic, hematologic, orthopedic, psychiatric or dental aspects of hemophilias or Von Willebrand's Disease. Focus may be on rehabilitation, therapeutic modalities or social features.

For an application, write or phone Cindy Kingsbury, National Hemophilia Foundation, 19 W. 34th St., Suite 1204, New York, N.Y. 10001—(212)-563-0213.

#### Final Rule on Attestation

The final rule on Attestation (for entry by the physician on all hospital charts involved in DRG) is as follows: "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."

Physicians annually must sign a statement (to be kept on file at each hospital where they have privileges) acknowledging they have received this notice:

"NOTICE TO PHYSICIANS: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws."

#### **Smoking and Facelifts**

There is a direct association between cigarette smoking and the ability to heal following a facelift. Dr. Thomas D. Rees, a plastic surgeon who practices in the Manhattan Eye, Ear, and Throat Hospital, retrospectively inquired as to smoking habits among 121 patients who had experienced skin sloughs after facelifts.

Eighty per cent of the patients followed admitted to smoking more than one pack a day. Dr. Rees thinks that the blood vessel constriction caused by nicotine is the cause of sloughing and poor healing. He now operates only on patients who promise to stop smoking for 10 days before operation and to refrain for three weeks after.

#### An Ounce of Prevention

Suggestion: Carefully review at frequent intervals your patient case load to insure that your volume of work does not make it difficult to devote adequate time to each patient.

Discussion: Meritorious malpractice suits are generally based on a departure from accepted standards of care and, although a strained patient load does not represent a "departure" per se, claim files reveal that this set of circumstances is one of the principal contributing factors in the generation of malpractice suits.

Inadequate appointment-treatment-consultation time has given rise to departures and their concomitant suits in the following activities:

Defense recommendation prepared by the Medical Liability Mutual Insurance Company, New York, N.Y.

•Informed Consent—patient claims too little time spent in fully explaining treatment-alternatives-risks-benefits.

•Examinations and Follow-ups—done hastily and not properly reviewed and documented.

•Histories—incomplete, with tragic results later in treatment, such as failure to document drug allergy.

•Hospital Rounds—especially if they are geographically difficult to cover; fatigue combined with too many patients has led to inadequate care and missed diagnoses.

•Office Visits—not to mention long waiting time to see doctor increases patient hostility and detracts from good doctor-patient relationships.

#### NEWS NOTES

#### **Bendectin Litigation**

Bendectin, an antiemetic drug once widely used for the relief of nausea and vomiting during pregnancy, should no longer be prescribed or dispensed, according to David B. Sharrock, president of Merrell Dow Pharmaceuticals, the former manufacturer.

Massive litigation involving claims against the drug prompted the action, but Mr. Sharrock says the firm "remains confident in the safety of Bendectin." Although the drug is still approved by the FDA for use, Merrell Dow stopped manufacturing it last year.

In July, a U.S. District Court in Cincinnati issued an order announcing a comprehensive plan to settle current and potential claims in the U.S. against Bendectin. Final settlement is expected this year, after which Merrell Dow will no longer be held liable for claims.

"This acceptance of settlement should not be construed as any admission of liability by the company," Mr. Sharrock said. "Our acceptance is based solely on business considerations, since medical data strongly supports the safety of Bendectin."

Bendectin had been available for 27 years and had been used in an estimated 33 million pregnancies worldwide. In 1977, a lawsuit was filed alleging Bendectin was responsible for the birth defect of a Florida child. Since then hundreds of additional lawsuits have been filed. To date, however, two lawsuits have been tried in courts and in both cases judgments have been in favor of Merrell Dow.

#### **New PMI Sheets**

The AMA has just published 21 new Patient Medical Instructions (PMI) sheets, bringing to 81 the total number of drugs and drug classes in the PMI series.

PMIs are designed to help physicians communicate drug information to their

patients at the time a prescription is written.

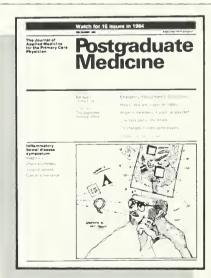
The new PMIs include: Glaucoma Eye Medicine—Miotic; Glaucoma Eye Medicine—Long-Acting; Glaucoma Eye Medicine—Epinephrine-type; Timolol—Ophthalmic; Sulfamethoxazole and Trimethoprim; Nitrofurantoin; Isoniazid, Ethamubutol and Rifampin; Colchicine; Probenecid and Sulfinpyrazone; MAO Inhibitor Antidepressants; Bromocriptine; Clomiphene; Estrogens—Oral; Sucralfate; and Sulfasalazine.

#### Physician Population

Physicians in the U.S. increase steadily. The enlargement from 1982 to 1983 totals 17,445—from 501,958 to 519,403, an increase of 3.8%. Women physicians increased by 11.5%. Foreign physicians grew in number during the same period by 3.6%. Physicians per 100,000 civilian population tallies 148 in 1970, 169 in 1975 and 195 in 1980.

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# News from the AMA

•The AMA's DRG Monitoring Project is collecting the observations of individual physicians about the impact of the new prospective pricing system in their hospitals. The AMA will use the information in pursuing modifications to the PPS and for developing programs to assist physicians in dealing with it. Physicians are asked to send their written comments to the DRG Monitoring Project, AMA Dept. of Health Care Resources, P.O. Box 10947, Chicago 60610.

•A 24-page booklet, "What Your Patients Should Know... About DRGs and the Prospective Payment System," is available from the AMA. The booklet is designed to help physicians in answering patient inquiries. It may also be read and understood easily by patients themselves. It describes how and why Congress developed prospective pricing, and provides an overview of how the system is intended to work in hospitals. Copies are available for \$1 each for up to 99 copies, 75¢ each for 100-500 copies, and 60¢ each in larger quantities. Write to AMA Order

Dept. OP-336, P.O. Box 10946, Chicago 60610.

•The delegate allocation at the AMA's interim meeting next month will be affected by AMA bylaws amendments approved at the 1984 annual meeting. A constituent association will be entitled to an additional delegate and alternate if 75% or more of its members are also AMA members. It will be entitled to two additional delegates and alternates if all of its members are also AMA members. The delegate allocation for the 1984 interim meeting will be based on membership information on record at the AMA as of June 21. For the 1985 annual meeting and for future meetings, the provision for additional delegates will be based on membership information as of Dec. 31 of each year.

•The AMA claim form, now the most widely used and accepted claim form in the U.S., has been updated and revised. The new form incorporates changes requested by the Health Care Financing Administration. Using the old form after Dec. 1 could delay reimbursement.

HCFA has approved the new form for Medicare and Medicaid. More than 30 Blue Shield plans use the AMA form. The Health Insurance Association of America also recommends it to 300 member companies. To receive an information packet, write to the AMA Dept. of Health Care Financing and Organization, AMA Headquarters, Chicago.

# Crisis Intervention

The CPC Valle Vista Hospital of Greenwood has formed a Psychiatric Assessment Team to provide 24-hour emergency aid for psychiatric crises.

P.A.T. counselors arrive at the scene of emergencies in Johnson County within 45 minutes. They aid police in situations that indicate a need for intervention by professionals experienced in handling emotional and psychiatric crises—attempted suicides, family conflicts, intoxication, rape, and so forth.

P.A.T. is being offered as a free community service.

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# NEWS NOTES

# Here and There . . .

**Dr. Clarence E. Ehrlich** of Indianapolis has been awarded the American College of Obstetricians and Gynecologists John McCain Memorial Fellowship. During the period of the fellowship he will live in Washington, D.C. to study the internal workings of the federal government and issues relevant to ACOG and other medical groups.

**Dr. Hans E. Geisler** of Indianapolis participated in a Mead Johnson symposium regarding hormones and female genital cancer in London Sept. 5-6.

**Dr. Donald Donner** of Bedford is a newly enrolled member of the American College of Radiology.

Mr. Jay F. Nash, a Purdue University doctoral candidate in pharmacology, has been awarded a research grant of \$2,500 by the Thompson Medical Company, New York, for research on "Stress Induced Ingestion of Pharmacologically Active Phenylethylamines by Rats."

**Dr. C. Richard Yoder**, an Elkhart pediatrician for 34 years, has retired from private practice.

**Dr. Jesus C. Bacala** of Scottsburg was named a "Distinguished Fellow" at this year's convention of the American College of International Physicians, held in Chicago.

**Dr. Thomas F. Orman** of Terre Haute has been certified in cardiovascular diseases by the American Board of Internal Medicine.

**Dr. Gary R. Fisch** of Indianapolis discussed new treatments in heart disease during a September meeting in Lawrence of Heart Felt Friends.

**Dr. Alfred A. Serritella** of LaPorte was the guest speaker at the September meeting of the Michiana Chapter, National Foundation for Ileitis and Colitis.

**Dr. Charles E. Rehn** of Indianapolis was guest speaker at the September meeting in Indianapolis of the Parkinson Awareness Association.

**Dr. Robert McDougal** of Danville has been elected president of the Blood Research and Education Foundation of Indiana, formed to support the Central Indiana Regional Blood Center.

**Dr. Donna A. Wilkens** of Muncie recently conducted a seminar for area EMTs, paramedics and nursery nurses on the "Stabilization and Transport of the Critically Ill Newborn."

**Dr. Diane S. Musgrave** of South Bend discussed arthritis during a September meeting of the Mishawaka Lions Club.

**Dr. Thomas F. Keough** of Warsaw discussed the "Disease Process" during a September meeting of Hospice Volunteer Companions.

**Dr. Frederick J. Ferlic** of South Bend was the guest speaker at a recent meeting of the Living with Arthritis Club.

**Dr. Ernest W. Stiller** of LaPorte discussed hip replacement surgery at a recent geriatric health forum in LaPorte.

Dr. Ara K. Yeretsian of Merrillville

discussed various aspects of depression during a recent community awareness seminar sponsored by the Alcoholism Institute of the Methodist Hospitals.

**Dr. Maurice E. John** of Jeffersonville was one of four American physicians invited to address the senior staff and residents of the University of Zurich's Ophthalmology Department in September.

**Dr. Michael S. Turner** of Indianapolis has been certified by the American Board of Neurological Surgery.

**Dr. Robert P. Acher**, a Greensburg general practitioner nearly 39 years, retired from practice Aug. 31; he was named Physician of the Year in 1971 by the Indiana Mental Health Assn.

# **Maglinte Nominated**

Dr. Dean D. T. Maglinte, Dept. of Radiology, Methodist Hospital of Indiana, has been nominated for a position on the Advisory Editorial Board of *Radiology*, the largest circulating radiology scientific publication in the world.

Radiology is published monthly by the Radiological Society of North America, home-based in Southfield, Mich.

Editorial board membership is limited to individuals who have contributed in a substantive way to the advancement of the clinical art and science of radiology.

# Physician Recognition Awards —



The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.



Baker, Leslie M., Aurora
Balter, Eugene L., Gary
Barker, John C., Indianapolis
Burney, Bryan T., Indianapolis
Chamberlain, Donald S., Mishawaka
Dillon, Gary P., Fort Wayne
Dittmer, Thomas L., Valparaiso
Friedman, Isadore E., Munster
Gartner, Joseph C., Jasper

Gize, Raymond W., Fort Wayne Guevara, Teodora G., Marion Hachmeister, Charles W., Evansville Jackson, Howard C., Madison Kissel, Wesley A., Indianapolis Kruse, Stephen K., Newburgh Loewenstein, Werner L., Terre Haute Madarang, Napoleon M., Hammond Mangahas, Jovencio P., East Chicago Mangahas, Violeta R., East Chicago

Marhenke, Jon D., Indianapolis McDougal, Robert A., Danville Michael, Isaac E., Indianapolis Polydefkis, Dimitri G., Munster Razek, Aly A., Evansville Shulruff, Harry I., East Chicago Villalta, Josue J., Indianapolis Vincent, John P., Greensburg Wooden, Thomas F., East Chicago

# **New ISMA Members**

The following physicians were welcomed in August as new members of the Indiana State Medical Association.

Marjorie L. Bush, M.D., Indianapolis, plastic surgery.

David D. Chopra, M.D., Lynn, internal medicine.

Henry D. Covelli, M.D., Anderson, pulmonary diseases.

Leo F. Czervionke, M.D., South Bend, radiology.

Themen S. Danielson Jr., M.D., Indianapolis, family practice.

Kenneth E. Elek, M.D., South Bend, family practice.

Paul Frederick, M.D., Noblesville, gastroenterology.

Cary L. Hanni, M.D., Beech Grove, cardiovascular surgery.

John C. Jarrett II, M.D., Indianapolis, obstetrics and gynecology.

Donald E. Kerr, M.B., Bedford, internal medicine.

Frederick L. Kuhn, M.D., Indianapolis, emergency medicine.



Jagdish D. Kulkarni, M.D., Marion, psychiatry.

Donald H. Lauer, M.D., Indianapolis, family practice.

Joseph C. Lee, M.D., South Bend, family practice.

Vidya B. Miller, M.D., Indianapolis, pathology.

Arndt E. Mueller, M.D., Marion, obstetrics and gynecology.

Pravin M. Patel, M.D., Crawfordsville, urological surgery.

Dana H. Reihman, M.D., Anderson, pulmonary diseases.

Earle U. Robinson Jr., M.D., Indianapolis, obstetrics and gynecology.

Kennth A. Shaver, M.D., Muncie, family practice.

Gerritt Smith, M.D., Lafayette, general surgery.

Craig K. Thorstad, M.D., Indianapolis, ophthalmology.

Cynthia L. Wills, M.D., Danville, family practice.

Byran R. Wipperman, M.D., South Bend, anesthesiology.

Vickie W. Wipperman, M.D., Mishawaka, family practice.

# For the Asking . . .

•"Low-Calorie Sweeteners," a 48-page booklet produced by the American Council on Science and Health, presents the results of an exhaustive study of the safety and usefulness of Aspartame, Saccharin, Cyclamate and other sweeteners. For a single, complimentary copy, send a stamped (37¢), self-addressed, business size (#10) envelope to Low-Calorie Sweetener Report, ACSH, 47 Maple St., Summit, N.J. 07901.

•Professional advice for those who are searching for a physician as an assistant or colleague may be obtained by corresponding with Health Care Personnel Consulting, c/o Health Care Group, 400 GSB Building, One Belmont Ave., Bala Cynwyd, Pa. 19004.

•"Adverse Reactions to Foods" has been published by the National Institute of Allergy and Infectious Diseases. The American Academy of Allergy and Immunology aided in the production. The monograph was edited by John A. Anderson, M.D., and Dorothy D. Sogn, M.D. Copies may be purchased at \$9.50 each from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

• Audio-Digest Foundation announces Audio-Digest Emergency Medicine, the foundation's 12th "Spoken Medical Journal" subscription service. The new, twice monthly audio cassette service started in September. For information, write A-DF, 1577 E. Chevy Chase Drive, Glendale, Calif. 91206.

•The Graduate School of Public Health, San Diego State University, offers a nine-month, full-time educational program. The Master of Public Health degree is awarded, with a major in Maternal and Child Health. Applications are now being accepted for August 1985. Write to Helen M. Wallace, M.D., Graduate School of Public Health, San Diego State University, San Diego, Calif. 82182.

•BNA Communications has a new catalog of training films/videos designed for training employees in safety in the work place. Another catalog outlines other films/videos in management development. The catalogs are free to professionals in human resource development. Contact Customer Service Dept., BNA Communications, 9439 Key West Ave., Rockville, Md. 20850—(301) 948-0540.

•The 3M Company, makers of the first cochlear implant device, will provide extensive information on indications for implantation, functioning of the various components and the training program the patient receives after the operation. Write to Otologic Products/3M, Dept. SU84-I02, 225-5S-ol, 3M Center, St. Paul, Minn. 55144.

•A special issue of *Rehabilitation Literature*, the journal of the National Easter Seal Society, was published in July/August. It was devoted to children and disability. Copies of "Children and Disability" (Vol. 45, No. 7-8) are available at \$5 each from the society at 2023 W. Ogden Ave., Chicago 60612.

•"Aspartame" is the title of a brochure issued by the Calorie Control Council. It discusses the new sweetener, its benefits, safety review and proper usage. Reference is made to the "multiple sweetener approach," which allows various artificial sweeteners to present their advantages and to compensate for the disadvantages of other sweeteners. Single copies are free of charge. Write the council at Suite 500-D, 5775 Peachtree-Dunwoody Road, Atlanta, Ga. 30342.

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# OBITUARIES.

# Henry R. Schroeder, M.D.

Dr. Schroeder, 61, an Evansville physician, was killed Aug. 30 in a tractor accident at his Holly Hills Nursery.

He was a 1946 graduate of the University of Louisville School of Medicine and was a post-World War II veteran of the Marine Corps.

Dr. Schroeder, a nationally recognized grower of hybrid azaleas and rhododendrons, was a member of the American College of Surgeons and a board-certified member of the American College of Obstetrics and Gynecology.

# Vernon A. Shanklin, M.D.

Dr. Shanklin, 103, who practiced medicine in Terre Haute for 70 years, died Sept. 8 at a Vincennes convalescent center.

He was a 1906 graduate of the Indiana Medical College and was a veteran of World War I. He moved to Vincennes after retiring in 1977.

Dr. Shanklin served for many years as examining physician for the State Athletic Commission and for the Indiana Amateur Athletic Union. Believed to be Indiana's second oldest physician, he was considered the state's oldest active member of the American Legion; Ft. Harrison Post 40 provided military gravesite honors.

Dr. Shanklin, a member of the ISMA Fifty Year Club since 1956, was credited with having delivered 8,000 babies in Vigo County during his long career.

# Charles H. Kenner, Jr., M.D.

Dr. Kenner, 34, a research fellow in the Division of Nephrology at Indiana University Medical Center, died Sept. 22 of injuries suffered when he was struck by a car while riding a bicycle in Indianapolis.

He was a 1978 graduate of Indiana University School of Medicine and was a member of the ISMA Resident Medical Society.

Dr. Kenner was a diplomate of the American Board of Internal Medicine. He was a member of the International Society of Nephrology, the American College of Physicians and the Indianapolis chapter of the National Medical Association.

# James F. DeNaut. M.D.

Dr. DeNaut, 76, a retired Knox physician, died Sept. 18 at Starke County Memorial Hospital.

He was a 1934 graduate of Northwestern University Medical School, Chicago. He retired in 1978.

Dr. DeNaut, a former president of the Starke County Medical Society, was a lifetime member and past chief of staff of Starke County Memorial Hospital. He was a member of the American Academy of Family Physicians and was posthumously enrolled in the ISMA Fifty Year Club at last month's annual convention.

# Lester W. Veach, M.D.

Dr. Veach, 91, a retired Bainbridge physician, died Aug. 20 at Methodist Hospital, Indianapolis.

He was a 1918 graduate of Indiana University School of Medicine and was an Army veteran of World War 1.

Dr. Veach, who retired in 1975, was a former president of the Putnam County Medical Society and was a member of the ISMA Fifty Year Club. He served as Putnam County health officer from 1961 to 1973.

# Robert H. W. Brosius, M.D.

Dr. Brosius, 73, a retired Fort Wayne physician, died Sept. 4 at Lutheran Hospital, Fort Wayne.

He was a 1935 graduate of Indiana University School of Medicine.

Dr. Brosius was a member of the American Academy of Family Physicians and the Fort Wayne Academy of Medicine and Surgery.

# C. Basil Fausset, M.D.

Dr. Fausset, 79, a retired Indianapolis neurosurgeon, died Sept. 14 at Methodist Hospital, Indianapolis.

He was a 1930 graduate of Indiana University School of Medicine and was an Army veteran of World War II. He retired in 1981 and moved to Brownsburg.

Dr. Fausset was a member of American and International College of Surgeons, the Congress of Neurological Surgeons and the American Association of Neurological Surgeons. He was a private pilot and belonged to the Aerospace Medical Association and the Flying Physicians Association. He became a member of the ISMA Fifty Year Club in 1980.

# **Memorials: Indiana Medical Foundation**

The Indiana Medical Foundation, Inc. was formed by the Indiana State Medical Association "for religious, charitable, scientific, literary or educational purposes." It provides financial assistance to support the educational mission of INDIANA MEDICINE.

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The Foundation is pleased to acknowledge the receipt of gifts in remembrance of the following individuals:

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# E. Daniel Williams, M.D.

Dr. Williams, 63, a Gary physician, died Aug. 28.

He was a 1946 graduate of Meharry Medical College, Nashville, and was a veteran of World War II and the Korean War.

Dr. Williams, a former deputy coroner for Lake County, was a member of the American Academy of Family Physicians.

# Roy V. Myers, M.D.

Dr. Myers, 92, formerly of Indianapolis, died Sept. 13 at his home in Lake Clarke Shores, Fla.

He was a 1920 graduate of Indiana University School of Medicine. He had practiced in Indianapolis 40 years before retiring in 1962.

Dr. Myers was a member of the ISMA Fifty Year Club.

# Herbert E. Dester, M.D.

Dr. Dester, 90, a retired Berne physician who was a former medical missionary in India, died Aug. 13 at a Berne retirement center.

He was a 1926 graduate of Indiana University School of Medicine and was an Army veteran of Word War I.

Dr. Dester, originally from Kansas, served in India for 30 years. He then moved to Greencastle and, from 1958 to 1963, served as full-time medical director at the Indiana State Farm. Upon his departure, he practiced in Berne until his retirement in 1972. He was a member of the ISMA Fifty Year Club.



Dr. Myers

# Ruth F. Rasmussen, M.D.

Dr. Rasmussen, 80, a retired South Bend clinical pathologist, died in August.

She earned the M.D. degree in 1932 from the University of Minnesota. She began practicing in South Bend the following year.

# John L. Rittmeyer, M.D.

Dr. Rittmeyer, 64, a retired Muncie internist, died Sept. 12 at his home.

He was a 1943 graduate of the University of Cincinnati College of Medicine and was an Army veteran of World War II.

Dr. Rittmeyer was plant physician at Delco Battery in Muncie for 10 years before retiring in 1982. Previously, he had been associated with the Ball State Health Center and the Muncie Clinic.

# Lloyd R. Studebaker, M.D.

Dr. Studebaker, 79, a retired LaGrange surgeon, died May 12, 1984.

He was a 1934 graduate of the College of Medical Evangelists, Loma Linda, Calif.

Dr. Studebaker was a former medical missionary in Nigeria. He was a former president of the LaGrange County Medical Society and was a former chief of surgery at LaGrange County Hospital. He was posthumously enrolled in the ISMA Fifty Year Club at last month's annual convention.

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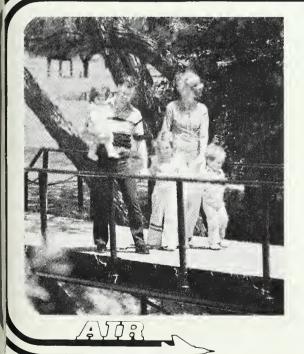
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# CME Quiz . . .

CONTINUED FROM PAGE 893

- 9. Most syphilis in the United States today occurs in:
  - a. U.S. military personnel.
  - b. prostitutes.
  - c. homosexual males.
  - d. immigrants from under-developed countries.
- 10. Cancer of the cervix appears to be most closely associated with:
  - a. gonococcal infections.
  - b. conduloma acuminatum (genital warts).
  - c. genital herpes.
  - d. no sexually transmitted agent.



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evaluation.

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instituting therapy

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with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, Gl pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, fry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients.* 15 mg recommended initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



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DECEMBER 1984

VOL.77

NO. 12

# INDIANA MEDICINE

The Journal of the Indiana State Medical Association



Results of the 1984 ISMA Annual Convention

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# INDIANA MEDICINE

Vol. 77, No. 12 DECEMBER 1984 WINNER Sandoz Medical Journalism Award—1976, 1979

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### **ABOUT THE COVER**

76 pages of this issue are devoted to a report of the ISMA's 1984 annual convention, conducted Oct. 19-22 in Indianapolis. As shown on our cover, Dr. Lawrence E. Allen of Anderson (left) succeeded Dr. George T. Lukemeyer as president of the Association. The convention section begins with photo coverage on page 988.—COVER BY FRED KINGHORN

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# MEDICAL MUSEUM NOTES

CHARLES A. BONSETT, M.D., Indianapolis



HE SPECIALTIES OF neurology and psychiatry have evolved as separate and distinct fields of clinical endeavor, from neuropsychiatry, which in turn evolved from internal medicine. The distinction between neurology and psychiatry was formalized in 1934 with the creation of the American Board of Psychiatry and Neurology. Dr. Alexander Ross (board-certified in both neurology and psychiatry) developed the residency training program in neurology at the Indiana University School of Medicine during the 1940s and made the formal break with psychiatry at the academic level at that time.

In comparison to other specialities, the number of physicians limiting their practice to the nervous and mental disorders has been small until recent years. By the 1930s a sufficient number existed to warrant the formation of a social-educational society known as the Indiana Neuropsychiatric Association (INPA). I inquired of Dr. E. Roger Smith back in 1969 (he was then 77 years old) as to the origin of INPA:

"Well, I'd give Toby Gilman the credit for the idea and the organization of this, although Verne Hahn might have had something to do with it. I think this was about 1936. The early members included Earl Mericle, Cliff Williams and John Greist. There was Verne Hahn, and a few others. There were about 16 members altogether, I think. We had monthly meetings. At first these were informal, and then Toby Gilman thought we should have a little more formality and had us showing up in formal wear. The meetings were usually held at the Athenaeum, sometimes at the Athletic Club."

The INPA organization endured into the 1960s. By that time the membership had grown considerably, with the psychiatrists far outnumbering the neurologists. The Indiana Neurological Society was incorporated in 1965 and the Indiana Psychiatric Society was established soon after.

The last thread connecting neurology with psychiatry was the combined section of ISMA's Annual Meeting. This year the



Dr. Walker

group was divided into two separate sections. The thread has been broken.

All of the above is prologue to the primary subject of this month's page of notes, which is to show and tell a little bit about the state's first neurologist and the first psychiatrist (in the sense that these men attempted to specialize in these areas to the extent then possible, and were the first recognized teachers of their respective subjects in an organized medical school).

The school was the College of Physicians and Surgeons, located in Indianapolis. The first neurologist was Dr. Isaac C. Walker (July 30, 1827-Oct. 28, 1906), and the first psychiatrist was Dr. Orpheus Everts (Dec. 26, 1826-June 20, 1903). The former taught "Diseases of the Nervous System" and the latter taught "Insanity." Most medical schools of this period in American history (the 1870s) made no mention of courses for nervous and mental disorders. To have a separate chair for each was highly unique.

Isaac Walker was born in Wilmington, Ohio. He graduated from the Wilmington Seminary in 1846, then read medicine for three years in the office of Dr. Amos T. Davis, a local physician. He then attended a series of lectures at the Cincinnati College of Physicians and Surgeons, where he received the M.D. degree. Dr.



Dr. Everts

Walker then moved to Peru, Indiana where he practiced for the next 14 years. In 1872 he moved to Indianapolis and was one of the founders of the College of Physicians and Surgeons. His biographical data mentions no postgraduate education so it is assumed that he was a self taught neurologist. His biographer (Sulgrove, 1884) describes him as the most eminent authority on nervous system disease in the "west," and mentions that Dr. Walker "has made numerous contributions to the medical literature" (only two of which are known at this time). These show the doctor to have a clear and instructive style of writing. (It is of interest that he attempted to relieve intracranial congestion associated with vascular accidents by the use of leeches placed up the nostrils.)

Less is known about Dr. Orpheus Everts. He was born in Salem, Indiana, and graduated from the Indiana Medical College at LaPorte in 1846. During the Civil War he served as surgeon of the Twentieth Indiana Volunteers. In 1868 he was appointed superintendent of the Indiana Hospital for the Insane, a position he held for 11 years. It was during this period that he taught in the medical school. At the time of his death he was superintendent of the Cincinnati Sanitarium.

# WHAT'S NEW?

Brentwood Instruments introduces a small, portable computer-aided ECG, the FCP-II. The FCP-II has a built-in microcomputer which measures the patient's ECG against standard criteria for over 100 precise interpretations, and offers a written opinion. Data from three separate leads plus the rhythm lead is acquired simultaneously, stored in the unit's memory, then displayed on the single channel chart. The three leads of information are acquired simultaneously, not sequentially, as in conventional single channel ECGs. The FCP-11 is a lightweight unit (less than 9 pounds) and is ideal for private practice, hospitals, emergency rooms, industrial clinics, nursing homes or even for house calls.

Kodak has published a new brochure to aid in evaluating accurately the true cost of operating a clinical analyzer and to determine how efficient the analyzer will be in meeting immediate and long-term needs. Entitled, "Kodak Ektachem Clinical Chemistry Products—Economic Benefits." The brochure presents all the factors that must be considered for an accurate assessment of cost.

The Medichart Corporation announces the availability of CHART, a new computerized health risk analysis service. The program is designed as an efficient tool for reinforcing physician recommendations to the patient. A short "CHART" questionnaire is filled out by the physician and patient, utilizing hard data such as blood pressure, weight, cholesterol and blood sugar. The analysis produces a statement of the patient's true health age and risks; it also presents recommendations for changes in health habits and risk reduction.

Gemini Incorporated announces a special wheelchair seat component for stroke victims. It was devised by Dr. S. T. Kucera and is named "Dr. K's Saddle Seat." It can be fitted firmly to the wheelchair seat. Its saddle contour conforms to the contour of the buttocks and prevents the patient from sliding forward. Paralytic patients have found it to be very comfortable.

A 45-page catalog of products for medical imaging is available from Eastman Kodak Company. The title is "Kodak Products for Medical Diagnostic Imaging." It lists all Kodak films for general radiography, CRT and video imaging, high-definition radiography, image-intensifier recording, radiation therapy and monitoring, and medical specialty films for substraction, kidney surgery and copying.

Park Surgical Company announces a speech amplifier for patients with speech inadequacy in which reinforcement of volume is necessary. It is helpful for sufferers of Parkinson's disease, vocal cord palsy and laryngectomy. It is suitable for those whose speech needs amplification but is not suitable for patients whose clarity of speech has deteriorated and has become unintelligible. It operates on standard 9-volt batteries and has adjustable volume control and an on/off switch.

The Arizona Heart Institute announces a technical improvement of the standard coronary artery angiograms as presented on film. The Arizona Heart Institute is demonstrating the use of CAMTEK 1000, a computer developed by Digital Imaging Company of America (DICOA), which can eliminate cine film. The CAMTEK 1000 captures the entire angiographic procedure in digital format and stores it on magnetic tape. The angiogram is thereafter available for instantaneous replay on a TV monitor. The image can be enhanced by special filtering techniques to improve diagnostic capability.

News of what is new in the medical supply industry is composed of abstracts from news releases by book publishers and manufacturers of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by INDIANA MEDICINE or by the Indiana State Medical Association.

Hewlett-Packard has introduced a family of three new PageWriter cardiographs, each designed to meet the distinct requirements of individual users and departments. The new products are I) HP 4760A PageWriter cardiograph with alphanumeric keyboard; 2) HP 4760AM PageWriter measurements cardiograph with the HP ECG measurements program; and 3) HP 4760AI PageWriter interpretive cardiograph with the full HP ECG analysis program.

Key Pharmaceuticals announces the acquisition, from Ipsen S. A. of France, of the exclusive U.S. marketing rights to a natural, non-fibrous, anti-diarrheal product that has a proven record of safety and efficacy in Europe. The product will be marketed as an ethical, non-prescription drug under the trademark "Diasorb." The new preparation will be available early in 1985.

Park Surgical Company has the new Park Electronic Artificial Larynx, JM 011. It is a lightweight, rechargeable device that promotes the approximation of natural voice once the laryngectomee adapts to it. It is 4½ inches long and 1¼ inches in diameter and weighs only 6 ounces with battery. It is supplied with battery charger, two batteries, an oral adaptor and carrying case.

The CRC Press announces a new journal, CRC Critical Reviews TM in Biocompatability. The increasing use of foreign materials in modifying or correcting living tissue has created a new body of scientific information. Critical Reviews will search the world literature and publish critical evaluations of worldwide clinical and research experiences. The subscription rate is \$104 per volume of four issues published in one year. Volume I, Issue I contains review of authoritative articles by experts from Sweden, Japan and England.

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# FUTURE FILE

# **Hand Surgery**

A course in "Complicated Problems in Hand Surgery" will be conducted by the American Society for Surgery of the Hand March 25-29 at Hotel Wildwood, Snowmass, Colo.

Tuition is \$500. Registration is limited, so advance registration is advised.

For a program and details, write to the ASSH at 3025 S. Parker Road, Suite 65, Aurora, Colo. 80014.

# The Hand Wound

A course on "The Hand Wound and Its Treatment" will be conducted by the American Society for Surgery of the Hand April 15-17 at the Southampton Princess Hotel, Southampton, Bermuda.

On each of the three days, the meetings will extend from 7-10 a.m. and 4-7 p.m. Tuition is \$400. Registration is limited, so advance registration is recommended.

For a program and details, write to the ASSH at 3025 S. Parker Road, Suite 65, Aurora, Colo. 80014.

# Thermography Seminars

Thermal Image Analysis, Inc. of Madison, Wisc. has announced its 1985 schedule of national thermography seminars:

Jan. 24-26—Houston March 27-29—San Francisco

June 13-15—New York, N.Y. Sept. 19-21—Atlanta

For further information, contact Thermal Image Analysis, 5510 Medical Circle, Suite B, Madison, Wisc. 53719—(608) 273-0362.

# Coping with Loss

The Menninger Foundation will conduct a workshop Feb. 6-8 in Topeka, Kan. on "Coping with Loss: The Experience of Grief."

Tuition is \$185, which includes a social hour and dinner on Feb. 6, but does not include other meals, lodging or transportation. Registration deadline is Jan. 16.

For a registration form and details, contact the Menninger Foundation, Box 829, Topeka, Kan. 66601—(913) 273-7500, ext. 5992.

# **Childhood Cancer**

"Advances in the Care of the Child with Cancer" is the subject of an American Cancer Society national conference to be conducted June 12-14 at the Los Angeles Hilton.

For details, write to the ACS at 777 Third Ave., New York, N.Y. 10017.

# **DEMEX 85 Exposition**

An international congress and exposition on management of major emergencies and disasters will convene April 28 through May I at the Indiana Convention and Exposition Center, Indianapolis.

The goal of the meeting, called "DEMEX 85," is to provide a forum for airing and sharing experiences, ideas, information and technology on managing major emergencies and disasters. Representatives of national governments, state and provincial governments, counties, municipalities, and business and industry will participate. Experts in the emergency services field will present histories of recent major emergencies and will summarize current knowledge about hazards.

For more information, contact Doug Crichlow, Emergency Management Information Services, 25 McLean Place, Indianapolis 46202—(317) 925-5198.

# Immunology and Cancer

"Immunology and Cancer" is the title of the 38th annual Symposium on Fundamental Cancer Research, which will meet Feb. 26 to March 1 at the Shamrock Hilton Hotel, Houston.

For details, contact Office of Conference Services, Box I31, M. D. Anderson Hospital and Tumor Institute, 6723 Bertner Ave., Houston, Tex. 77030—(713) 792-2222.

The Journal of the American Medical Association publishes a list of CME courses for the United States twice yearly. The January listing features courses offered from March through August; the July listing features courses offered from September through February.

## Ski Conference

The sixth annual Mammoth Mountain Emergency Medicine Ski Conference will be held March 10-15 at Mammoth Lakes, Calif.

Fees are \$325 for physicians, \$190 for nurses, and \$225 for physicians in training and physician's assistants. The program is accredited for 20 hours, Category 1.

Contact Daniel L. Abbott, M.D., Medical Conferences, P.O. Box 52-B, Newport Beach, Calif. 92662—(714) 650-4156.

# **Nutrition Meeting**

The American Society for Parenteral and Enteral Nutrition will conduct its 9th Clinical Congress Jan. 21 to 24 at the Fontainbleau Hotel, Miami Beach, Fla.

For details write or phone A.S.P.E.N., 1025 Vermont Avenue, NW, Suite 810, Washington, D.C. 20005—(202) 638-5881.

# **Pediatric Brain Insults**

"Brain Insults in Infants and Children: Pathology, Evaluation, Diagnosis and Acute Management" is the title of a CME conference to be held March 7-9 at the Holiday Inn at the Embarcadero, San Diego. AMA/CMA credit is 17 hours.

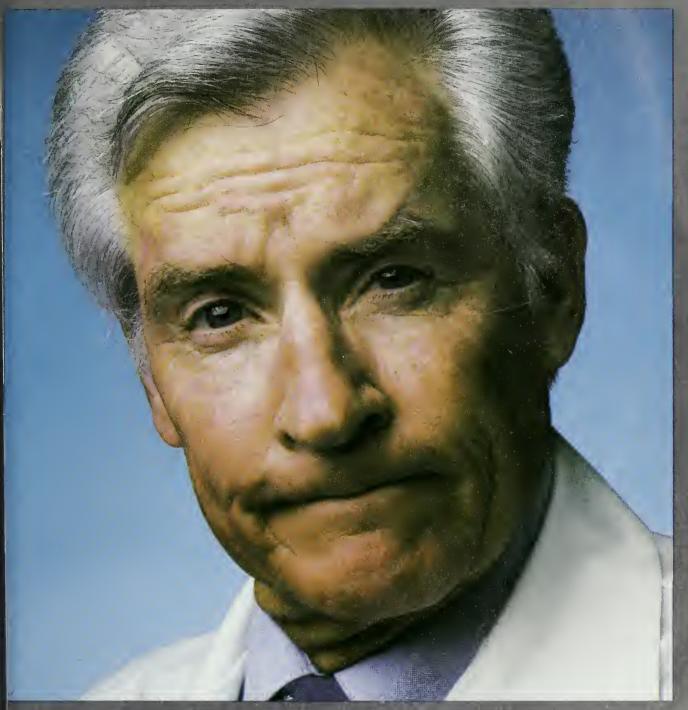
Contact Office of CME, MO17 UC San Diego School of Medicine, La Jolla, Calif. 92093—(619) 452-3940.

# Clinical Cytopathology

The Johns Hopkins University School of Medicine will offer two postgraduate courses in clinical cytopathology next year. They are solely for pathologists.

For credit, both courses must be taken: March to May 1985, Home Study Course A is provided each registrant for intensive personal study; and from May 6-17 In-Residence Course B will be conducted at the Johns Hopkins Medical Institutions, Baltimore. Upon successful completion, 152 AMA Category 1 credit hours will be awarded.

For details, write John K. Frost, M.D., 604 Pathology Bldg., The Johns Hopkins Hospital, Baltimore, Md. 21205.



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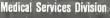
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Clinical Oncology Center Methodist Hospital of Indiana, Inc. New information from Indiana Division American Cancer Society, Inc. 4755 Kingsway Dr., Suite 100 Indianapolis 46205

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# CANCER CORNER

#### Patient Education

Recognizing the concerns that cancer patients and their families have about their ability to maintain or secure a job or insurance after a cancer diagnosis, a new patient education booklet, "Cancer—Your Job, Insurance and the Law," has been developed.

The booklet provides an overview of the issues, and stresses the importance of patients becoming aware of their rights under the law. The American Cancer Society divisions and units are cited as a source of specific information on state and local laws and regulations about employment and insurance rights. Units should use this brochure to help their Information & Guidance program.

Copies of the booklet (Code #4585) may be ordered from the Division Distribution Department.

#### **Professional Education**

A new film, "Proctosigmoidoscopy in the Physician's Office," is now available for unit distribution. This film will be used in conjunction with the Colorectal Health Check Program.

The earlier film, "Proctosigmoidoscopy—A Part of the Physical Examination," Code #3721, has been withdrawn from distribution (no flyer).

DESCRIPTION: This new film describes the uses of rigid proctosigmoidoscopes and of the newer flexible fiber-optic scopes. The procedure is demonstrated on patients with both types of instruments and the maneuvers to negotiate turns, folds and valves in the colon are explained.

The importance of this cancer detection procedure in conjunction with digital examination and stool blood testing is emphasized for all asymptomatic adults over age 50. ACS guidelines for frequency are summarized, and the need for proper training and observance of precautions are stated.

SPECIFICATIONS: Code #3793.

SUGGESTED AUDIENCES: Primary care physicians, medical and osteopathic students and allied health professionals. It can be presented to hospital physicians as an in-service Professional Education Program.

SUGGESTED ACCOMPANYING MATERIALS (PUBLICATIONS):

Early Diagnosis of Colorectal Cancer (Code #3311)

The Evolving Surgical Treatment of Rectum and Colon Cancer (Code #3302)

Current Clinical Practices (Code #3356)

Current Status of Fecal Occult Blood Testing and Screening (Code #3426)

Early Detection of Colorectal Cancer (Film flyer) (Code #3084)

#### Animals and Medical Research

The American Cancer Society has not officially adopted a position on the national level regarding the use of animals in research.

Many ACS divisions have been approached by groups on both sides of the issue seeking support for legislation that would outlaw or support the use of animals in medical research.

Some animal "protection" groups have argued that animals used in medical research suffer needless pain and cruelty.

Supporters of using animals in medical research have pointed out that great advances in medicine have been achieved through the use of animals. They cite development of the rabies vaccine, the germ theory of bacterial infection, and sterile surgical techniques as examples of these positive outcomes.

Conclusion: Many questions remain to be answered. The animal-rights activists are divided over their goals and objectives. Some favor total prohibition against any animals being used in medical research. Others favor prohibiting the use of only pound animals for such purposes. Laws regulating the use of animals in research are currently on the books in many states. Other states are considering proposed laws. The medical/scientific community agrees that the use of animals is necessary in research projects. Some indicate that current technology allows for fewer animals being needed and that a day may come when animals will not be needed.

#### Psychosocial Research

The American Cancer Society is now funding research into another side of cancer—what the disease does to people psychologically and socially, besides physically.

Psychosocial research in cancer is a new field that has developed over the last 10 years. The society recently allocated nearly \$1.5 million to support nine research projects. Current projects include investigations into:

- how the attitude and behavior of physicians affect cancer patients, both positively and negatively;
- the prevention of nausea in patients when they merely think of taking drugs that nauseate them;
- how effectively adolescent patients follow drug instructions;
- the treatment of psychological and sexual concerns of men and women after treatment for certain cancers; and
- the best screening of high-risk persons for colorectal cancer.

The other side of cancer involves increasing concerns and commitments to cured patients as more and more people—currently about half—survive cancer. Cancer patients often have a sense of being damaged or impaired, not in control of themselves, and of needing help in reestablishing health attitudes and normal functioning.

Research is increasing toward understanding the interplay between the human body, mind and emotions.

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#### References

- Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy
  of diltiazem hydrochloride for the treatment of stable angina
  pectoris: Report of a cooperative clinical trial. <u>Am J Cardiol</u>
  49:560-566, 1982.
- Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exerciseinducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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Diltrazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 3D mg or 6D mg diltiazem hydrochloride for oral

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increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal

reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, dilitiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential Dilitiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accommanded by disper-dependent decreases in sysmodels and are accompanied by dose-dependent decreases in sys-temic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricu-lar conduction in solated tissues and has a negative inotropic effect in solated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

interval can be seen at higher doses. In man, diltazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inortopic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

of ditiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem. Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/dav has resulted in small increases in PR interval, but has not

cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 24D mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Dilitiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl dilitizem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as dilitiazem. Therapeutic blood levels so the following single or the parent drug and is 25% to 50% as potent a coronary vasodilator as dilitiazem. Therapeutic blood levels of QARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are departure from dose-linearity when single doses above 6D mg are given, a 12D-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

## INDICATIONS AND USAGE

Angina Pectoris Due to Coronary Artery Spasm. CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment

Chronic Stable Angina (Classic Effort Associated Angina).

CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in

reducing angina frequency and increasing exercise tolerance. There are no controlled studies of the effectiveness of the concomi tant use of diltiazem and beta blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities

#### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

#### WARNINGS

1. Cardiac Conduction, CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recov-ery time, except in patients with sick sinus syndrome. This ery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction A patient with Prinzmetal's anglia developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.

Congestive Heart Failure. Although diltiazem has a negative

inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should

be exercised when using the drug in such patients. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic

 Acute Hepatic injury. In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes (See PRECAUTIONS and ADVERSE REACTIONS.)

#### **PRECAUTIONS**

PRECAUTIONS
General. CARDIZEM (dittiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage in special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

WARNINGS)

Controlled and uncontrolled domestic studies suggest that con-comitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed

In rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 2D times

the human dose or greater.

There are no well-controlled studies in pregnant women; therefore use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk. exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential

risks in this situation.

Pediatric Use. Safety and effectiveness in children have not

#### **ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been

In domestic placebo-controlled trials, the incidence of adverse

in domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%),

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (13 astheria (1.2%), AV block (1.1%), In addition, the following eve were reported infrequently (less than 1%) with the order of presention corresponding to the relative frequency of occurrence

Flushing, arrhythmia, hypotension, brady dia, palpitations, congestive heart falls Cardiovascular

syncope. Paresthesia, nervousness, somnoler tremor, insomnia, hallucinations, and amne Constipation, dyspepsia, diarrhea, vomit mild elevations of alkaline phosphatase, SC

Nervous System:

Gastrointestinal

SGPT, and LDH. Pruritus, petechiae, urticaria, photosensit Polyuria, nocturia. Dermatologic

The following additional experiences have been noted A patient with Prinzmetal's angina experiencing episode vasospastic angina developed periods of transient asymptom asystole approximately five hours after receiving a single 60 dose of CARDIZEM

dose of CARDIZEM

The following postmarketing events have been reported iguently in patients receiving CARDIZEM, erythema multiforme kopenia, and extreme elevations of alkaline phosphatase, S GGPT, LDH, and CPK. However, a definitive cause and effect between events and CARDIZEM therapy is yet to be established.

#### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been lim Single oral doses of 300 mg of CARDIZEM have been well toler by healthy volunteers. In the event of overdosage or exagge response, appropriate supportive measures should be employ addition to gastric lavage. The following measures may be considered.

Bradycardia Administer atropine (0.6D to 1.0 mg) #f

Administer artispine (0.00 to 1.0 flig) if is no response to vagal blockade, admir isoproterenol cautiously Treat as for bradycardia above. Fixed degree AV block should be treated with

Black Cardiac Failure

High-Degree AV

Hypotension

degree AV DIOLA SHOULD SEE (ISOPROTEI Administer inotropic agents (Isoprotei dopamine, or dobutamine) and diuretics Vasopressors (eg., dopamine or levant

bitartrate).

Actual treatment and dosage should depend on the severity clinical situation and the judgment and experience of the tre

The oral/LD<sub>so</sub>'s in mice and rats range from 415 to 740 r and from 560 to 810 mg/kg, respectively The intravenous LD these species were 60 and 38 mg/kg, respectively. The oral dogs is considered to be in excess of 50 mg/kg, while lethalit seen in monkeys at 360 mg/kg. The toxic dose in man is not k but blood levels in excess of 800 ng/ml have not been asso with toxicity

#### DOSAGE AND ADMINISTRATION

DOSAGE AND ADMINISTRATION
Exertional Angina Pectoris Due to Atheroscierotic |
nary Artery Disease or Angina Pectoris at Rest Due to
nary Artery Disease or Angina Pectoris at Rest Due to
nary Artery Spasm. Dosage must be adjusted to each pa s
needs. Starting with 30 mg four times daily, before meals if
bedtime, dosage should be increased gradually (given in \( \)
doses three or four times daily) at one- to two-day interval if
optimum response is obtained. Although individual patient if
respond to any dosage level, the average optimum dosage, is
appears to be 180 to 240 mg/day. There are no available data or
ing dosage requirements in patients with impaired renal or I is
function. If the drug must be used in such patients, titration sh. is
carried out with particular caution.

carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. Sublingual NTG may be taken as required to abort anginal attacks during CARDIZEM therapy.

2. Prophylactic Nitrate Therapy — CARDIZEM may be coadministered with short- and long-acting nitrates. but have been no controlled studies to evaluate the anti-effectiveness of this combination.

3. Beta-blockers. (See WARNINGS and PRECAUTIONS.)

#### **HOW SUPPLIED**

Cardizem 30-mg tablets are supplied in bottles of 10 M 088-1771-47) and in Unit Dose Identification Paks of 10 M D088-1771-49). Each green tablet is engraved with MARION side and 1771 engraved on the other CARDIZEM 6D-mg tablets are supplied in bottles of 100 (NDC 0088-1772-47) and Dose Identification Paks of 1D0 (NDC DD88-1772-49). Each lablet is engraved with MARION on one side and 1772 on the Institute of 100 (NDC DD88-1772-49). Each lablet is engraved with MARION on one side and 1772 on the Institute of 1772 on Issued

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\*Data on file, Institute for Health Maintenance.

# The Risk Factor Obesity Program Medically designed. Medically supervised. Medically sound.

\*\*CL... Medically designed. Medically supervised. Medically sound

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To obtain Category 1 credit for this month's article, complete the quiz on page 975.



# **Breast Cancer 1984: State of the Art**

GEORGE W. SLEDGE, JR., M.D. Indianapolis

REAST CANCER is the most common cause of death due to cancer in American women. In 1984 this disease will strike more than 100,000 women in the United States. Despite recent advances in both the diagnosis and treatment of this disease, there has been relatively little change in breast cancer mortality rates in recent decades.

In this article I will outline some of the more important recent changes in our understanding of the natural history and management of breast cancer. I will suggest that we now have available diagnostic and therapeutic tools that, properly applied, could significantly benefit most victims of breast cancer, decreasing both the morbidity and the mortality of the disease.

**Natural History** 

Throughout most of the twentieth century, the guiding concept of the biology of breast cancer was that derived from the pioneering surgical investigations of William Halsted. This concept can be

characterized as follows: Breast cancer undergoes an orderly progression from local (breast) to regional (lymph node) to distant (metastatic) disease. In this progression, the regional lymph nodes (either axillary or internal mammary) act as anatomical barriers to disease. A logical consequence of this concept was that death in breast cancer was due to either the failure or inability of the surgeon to eradicate all local and regional disease prior to the development of metastatic disease

This "Halstedian" concept of breast cancer led to strenuous efforts to remove all possible sites of local-regional disease. The apotheosis of this concept came with the extended radical mastectomy, a procedure in which the surgeon removed the breast, the pectoralis major and minor muscle groups, and both the axillary and internal mammary lymph node groups contiguous with the tumor-bearing breast.

An alternate hypothesis, derived both from the laboratory and the clinic, has gained impressive support and general ac-

The author is an Assistant Professor of Medicine, Indiana University School of Medicine.

Correspondence: Indiana University School of Medicine, Div. of Hematology-Oncology, Dept. of Medicine, Long Clinical Bldg., Rm. 379, 541 Clinical Drive, Indianapolis, Ind. 46223.

ceptance in the past decade. In this formulation, breast cancer is seen as a disease capable of metastasizing at either an early (axillary-node-negative) or late (axillary-node-positive) date, with certain subgroups of node-negative patients having an equal likelihood of metastasis as node-positive patients. The regional lymph nodes, the alternate hypothesis states, are not in and of themselves adequate barriers to disease. Instead, the lymph node status of the disease serves only as an imperfect biological marker of the presence or absence of metastatic disease. In this formulation, adequate local control of disease (either through surgery, radiotherapy, or a combination of the two) will have little effect on the ultimate outcome of already-present systemic disease. The presence of systemic disease, in most node-positive and some node-negative patients, mandates the use of systemic therapy for the treatment of patients with breast cancer.

### Steroid Receptors

Steroid receptors are the Rosetta Stone of breast cancer. Their discovery in the late 1960s led to a greatly improved understanding both of the biology of breast cancer and of the best means of treating patients afflicted with the disease.

The prototypical steroid receptor in breast cancer is the Estrogen Receptor, or ER. As its name implies, the estrogen receptor is the cytosolic protein responsible for binding estrogens (particularly estradiol) entering the breast cancer cell. In addition, the estrogen receptor complex is responsible for mediating estrogenic effects in the cancer cell, through a poorly-understood interaction with the cell nucleus. These effects are too numerous to list here, but include cell growth and the induction of numerous cell proteins. One of these cell proteins, Progesterone Receptor (PgR), has been found to be an excellent measure of the intactness of the steroid receptor pathway in the breast cancer cell.

The presence or absence of steroid receptors (ER and PgR) in a breast tumor forms an important biological dividing line. Breast cancers lacking steroid recep-

tors are characterized by great biologic aggressiveness, with rapid doubling times, early recurrence, and a tendency to metastasize to vital organs such as the brain and the liver. Steroid-receptorpositive tumors, on the other hand, tend to have slower doubling times, tend to recur later following primary therapy, and are more likely to have an early metastasis in bone than in the brain or liver. Steroid receptors also play an important role in the clinical management of the disease; this will be discussed at greater length below.

## Diagnosis and Screening

Although breast cancer is an extremely common tumor, we lack a good means of predicting exactly which women will come down with the disease. While certain risk factors (a positive family history, early menarche, late age at first childbirth, exposure to radiation, and perhaps high dietary fat intake) increase the risk of developing breast cancer, no risk factor analysis presently available allows one to predict which specific individuals will develop the disease. For this reason, propyhlatic mastectomies probably are never indicated on the basis of a clinical history.

Two simple diagnostic procedures are known to improve both the early detection of, and survival in, breast cancer. These procedures are breast self-examination and mammography. In prospective, randomized trials, women taught to perform routine breast self-examination routinely discovered their tumors at an earlier stage than women not so taught. Similarly, large national studies have now demonstrated that routine mammography, given to women over the age of 40, results in the detection of breast tumors at an early stage, and improves overall survival. The American Cancer Society now recommends that all women between the ages of 40 and 50 have mammography every one-two years, and that all women over the age of 50 have mammography annually.

#### **Primary Therapy**

By primary therapy I refer to the

removal of tumor from the breast and the ipsilateral axillary lymph nodes. It has become increasingly evident in recent years that there are several equally effective ways of performing this task, at least for patients with early stage (Stage I and II) breast cancer. Much of the controversy surrounding the management of these patients could be avoided by a careful reading of the available scientific literature.

A reasonable place to begin is with the National Surgical Adjuvant Breast Project's protocol B-04. This protocol, carried out by a large national cooperative group or surgeons, pathologists, radiotherapists, and medical oncologists, compared different ways of managing localregional breast cancer in a prospective, randomized fashion. In axillary-lymphnode-negative patients, therapy consisted either of a standard Halsted-type radical mastectomy or of a total (simple) mastectomy combined with radiation therapy to the breast, or of a total mastectomy alone. Axillary-node-positive patients received either a radical mastectomy or a total mastectomy combined with radiation.

The results of this trial, with an average follow-up of nine years, are interesting. For axillary-node-negative patients, there are no differences in survival between the three treatment groups. Similarly, there are no differences in survival between node-positive patients receiving a radical mastectomy and those receiving a total mastectomy and post-operative radiation. These results surprised many advocates of the classical Halsted radical mastectomy. Perhaps even more surprising was the fact that there were also no statistically significant differences in local recurrence rates between the various therapies.

Randomized prospective trials have also been performed comparing various surgical approaches in the absence of radiotherapy. To date, these trials have revealed no difference in survival between the so-called extended radical mastectomy (in which the internal mammary nodes are removed) and the standard radical mastectomy, nor any difference between the radical mastectomy and the modified radical mastectomy (in which the pec-

toralis major muscle is left intact).

Taken together, these studies would suggest that there is no "best" surgical approach to breast cancer, no "gold standard" against which all other modalities must be compared. All of the studies tend to confirm an extremely important biological principle, namely that the ultimate destiny of the patient with breast cancer depends on the presence or absence of metastatic disease rather than the complete excision of all possible local-regional disease.

All of the above-mentioned studies involved, as a minimum, the total removal of the involved breast. Mastectomy can be a psychologically devastating procedure for the woman with breast cancer. Recent studies have asked whether adequate local control might be attained with less-mutilating therapy.

While this question has not yet been adequately answered for all patients with Stage I and II breast cancer, we can give a qualified "yes" for certain groups of patients. We currently lack, and may never have, prospective randomized studies allowing us to make definitive statements for all patients with early stage breast cancer. For patients with small (2) cm.) primary tumors, a randomized study from the National Tumor Institute of Milan, Italy has conclusively demonstrated that a quadrantectomy (i.e., surgery in which the breast quadrant containing tumor is resected) combined with radiation therapy to the breast and the lymph nodes draining the breast is the equal of a radical mastectomy both in terms of local control and overall survival

Several non-randomized, retrospective trials of segmental mastectomy or lumpectomy combined with effective local irradiation (usually involving either an iridium implant or electron beam therapy) have been performed for both Stage I and II patients. Comparison of these trials (many of which now have relatively long follow-up periods) with surgical historical controls suggests that segmental mastectomy or lumpectomy, when combined with effective local therapy, provide local control and long-

term survival rates that are the equal of those obtained with more aggressive surgical approaches, and with significantly better cosmetic results.

The National Surgical Adjuvant Breast Project is now performing a randomized trial comparing total mastectomy to segmental mastectomy and radiation to segmental mastectomy alone, all patients receiving an axillary node dissection for purposes of staging. The results of this innovative trial are eagerly awaited.

The management of early breast cancer remains controversial. It is not my purpose here to suggest the superiority of one approach over any other. Rather, the current literature suggests that several approaches are equally effective for controlling local disease and safeguarding long-term survival. Not all women are alike, either in age, tumor volume, or psychological makeup. The young patient with a small breast mass may prefer lumpectomy and radiation therapy for cosmetic reasons; the older woman may prefer more extensive surgery without the inconvenience and expense of weeks of radiotherapy, and may or may not avail herself of reconstructive plastic surgery. Therapy must be individualized rather than straight jacketed. The physician seeing a patient with early breast cancer should honestly and openly discuss alternative therapies, and be willing to refer his patient to colleagues in surgery and radiotherapy.

#### **Adjuvant Therapy**

The ultimate fate of the patient with breast cancer seems to depend on the biology of the tumor rather than the specific type of primary therapy. This realization has led many physicians to administer adjuvant therapy in an attempt to alter the course of the disease in those patients with a high probability of recurrence following local-regional therapy. Such patients include all those with involved axillary lymph nodes, and axillarynode-negative patients whose tumors lack steroid receptors. On the basis of past experience, these patients can be expected to have residual micrometastatic disease, which in theory might be eradicable with repetitive courses of cytotoxic chemotherapy, hormonal manipulation, or a combination of both.

In practice, adjuvant chemotherapy has proven to be somewhat more problematic than theory might suggest. Several welldesigned, randomized trials have suggested an improvement in disease-free survival (the period from primary therapy to disease recurrence) in patients receiving adjuvant therapy. Unfortunately, many of these studies have not demonstrated an improvement in overall survival; i.e., there is no evidence in these trials that the administration of adjuvant chemotherapy would improve the cure rate in breast cancer. While an improvement in disease-free survival is a laudable goal, it is not a sufficient one by itself when purchased at the expense of often substantial drug-induced toxicity.

Perhaps the most impressive adjuvant chemotherapy trial performed to date is that of the Southwest Oncology Group, in which a five-drug regimen (CMFVP, for cyclophosphamide, methotrexate, 5-fluorouracil, vincristine, and prednisone) was demonstrated to be superior to single-agent melphalan, both in terms of disease-free and overall survival. In this study a combination of active agents was administered for a year, with one of the agents (cyclophosphamide) being administered by mouth on a daily basis. Whether or not the continuous administration of such an agent is a necessary ingredient for success is unknown. Nevertheless, this study has provided encouragement to those who believe that adjuvant therapy has a positive role to play in the patient with resectable, early-stage breast cancer.

Two recent trends in the adjuvant therapy of breast cancer should be noted. The first is a trend toward a shorter duration of therapy. An impressive study from the National Tumor Institute of Milan has suggested that six months of adjuvant therapy is equal (and perhaps superior) to 12 months of therapy in terms of disease-free survival. This important finding needs confirmation; much of the morbidity of adjuvant therapy results from cumulative effects of repeated cycles

of drugs. The Southeast Cancer Study Group (of which Indiana University is a member institution) has data from a recently completed adjuvant trial suggesting the opposite of the Milan group's results, with an improved outcome for patients receiving prolonged therapy.

The second trend involves the use of adjuvant hormonal therapy, either in combination with chemotherapy, or as a single agent in steroid-receptor-positive patients. The National Surgical Adjuvant Breast Project has published the early results of a trial suggesting that the addition of the steroid antagonist tamoxifen to combination chemotherapy results in an improvement in disease-free survival in postmenopausal patients. These results should be received with great caution; the addition of tamoxifen, in this trial, actually worsened outcome in premenopausal steroid-receptor-negative patients, had no effect in premenopausal steroidreceptor-positive patients, and benefited postmenopausal patients independent of their steroid receptor status. None of these effects are predictable based on our understanding of how tamoxifen works in patients with metastatic breast cancer.

Similarly, although there are now several studies suggesting that tamoxifen may improve the disease-free survival of the elderly steroid-receptor-positive patient when used as a single agent, there are no studies suggesting that these patients have any survival advantage when compared to untreated controls. Tamoxifen in this situation may do no more than delay the onset of clinically evident disease. The temptation to offer the elderly patient a relatively nontoxic, potentially beneficial drug, while great, is best avoided until there is solid evidence suggesting a real survival benefit. Tamoxifen, although relatively safe to administer, is certainly not inexpensive.

To summarize this discussion of adjuvant therapy, there is sufficient evidence to suggest that such therapy improves disease-free survival, but less impressive evidence regarding a long-term survival advantage. The beneficial effects of adjuvant hormonal therapy remain unproven. Indiana University, through the

Southeastern Cancer Study Group, is actively involved in research in this area; currently we are testing which of the two most commonly used regimens provides the best treatment results.

# Management of Metastatic Disease

The patient with documented metastatic breast cancer is, in almost all cases, doomed to die of her disease. Given this grim fact, and until better therapy becomes available, the role of the physician becomes that of providing the greatest prolongation of life with the least morbidity. This is best performed through judicious use of hormonal therapy, chemotherapy, and—for localized problems such as metastatic disease in weightbearing bones—radiotherapy and surgery.

Steroid receptors provide the key to the management of metastatic breast cancer. There is overwhelming evidence that tumors lacking steroid receptors (ER and PgR) rarely respond to hormonal manipulations. These tumors are best treated initially with combination chemotherapy. Combination chemotherapy results in objective responses in 50-75% of patients with metastatic disease. These remissions tend to be partial rather than complete, and last on the average about nine months.

Steroid-receptor-positive patients frequently respond to hormonal manipulation. The likelihood of response seems to depend on both the absolute quantity of steroid receptor and on the type of steroid receptor present in the tumor. For instance, roughly half of all ER-positive patients respond to hormonal therapy but two-thirds to three-quarters of patients with either high quantitative ER (> 100) or with PgR in their tumor will respond.

The form of hormonal manipulation to be used depends upon the individual patient. Ablative endocrine therapy, in the form of ovariectomy, is the treatment of choice in the premenopausal steroid-receptor-positive patient, since these patients' tumors probably grow in response to the high circulating levels of estradiol present in their serum. In the postmenopausal steroid-receptor-positive patient,

the antiestrogen tamoxifen is currently the hormonal therapy of choice, given its extremely low degree of toxicity.

Several other agents are available either as second-line therapy, or as acceptable substitutes for tamoxifen in the rare patient unable to use it as first-line hormonal therapy. These agents include highdose estrogens (such as diethylstilbestrol), progestins (such as megestrol acetate and medroxyprogesterone acetate), and the agent aminogluthethimide. Aminogluthethimide, a relatively new drug in breast cancer therapy, acts to decrease circulating estrogen levels by inhibition of adrenal steroidogenesis (so-called "medical adrenalectomy") and by prevention of peripheral aromatization of androgens to estrogens. Because the drug has relatively little effect on the premenopausal ovary, its use should be limited to the postmenopausal patient and the patient who has undergone ovariectomy.

Patients who initially respond to hormonal therapy, and then develop progressive disease, frequently respond to a second form of hormonal therapy. These secondary responses, which may occur in as many as 50% of initial responders, can be of prolonged duration. Therefore, the patient progressing following an initial response should not immediately be given chemotherapy. A smaller percentage of steroid-receptor-positive patients failing initial hormonal therapy will respond to a secondary form of hormonal manipulation. In these patients it is reasonable to attempt a second hormonal manipulation if the patient does not have either rapidly progressive disease or disease involving a vital organ. Patients who are refractory to hormonal manipulation should receive combination chemotherapy, and have response rates and response durations similar to steroid-receptor-negative patients.

## **Future Directions**

Patients with metastatic breast cancer eventually succumb to their disease. Several innovative approaches have been attempted in recent years in hopes of altering the present grim reality. Com-

binations of hormonal therapy and chemotherapy have been used in hopes of taking advantage of the differing actions and toxicities of the two classes of drugs. These trials have not demonstrated superior efficacy to sequential use of hormonal manipulation and chemotherapy.

An extremely interesting new approach is based on the laboratory observation that physiologic doses of estrogens are capable of inducing cell division in steroid-receptor-positive tumor cells, and in addition can overcome antiestrogeninduced blocks in tumor cell division. Based on this observation, patients with metastatic disease have been administered the antiestrogen tamoxifen to block

tumor cells in the G1 stage of the cell cycle. The synchronized tumor cells are then induced to enter the cell cycle with the estrogenic compound premarin. The synchronously cycling cells are then treated with a combination of cell-cycle-active drugs.

Initial reports of this approach have been extremely promising, although the final verdict will depend on the completion of a prospective, randomized trial specifically designed to treat this hypothesis. Such a trial, designed at the Indiana University School of Medicine, will begin accruing patients in the Southeastern Cancer Study Group in the near future.

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# Indiana's Craniofacial Anomalies Team

# Special Care at the James Whitcomb Riley Hospital for Children

CHARLES L. NELSON, D.D.S.<sup>1</sup> DIANA McDOWELL, R.N., M.S.N.<sup>2</sup> A. MICHAEL SADOVE, M.D.<sup>3</sup> Indianapolis HILDREN WITH CRANIOFACIAL anomalies (Figs. 1,2,3) present such complex diagnostic and therapeutic problems that many health care specialists need to be involved in the evaluation and treatment of these patients. Although the evaluations by specialists may be independent of one another, it is desirable that their treatment plans be integrated.

The Craniofacial Anomalies Team at the James Whitcomb Riley Hospital for Children on the Indiana University Medical Center campus was formed to meet the special needs of patients with such anomalies throughout Indiana and surrounding states. The team consists of approximately 25 individuals respresenting 20 medical, dental and allied health specialties. This article describes the Craniofacial Anomalies Team and its function at the Indiana University Medical Center.

The incidence of craniofacial anomalies is not particularly high. Christiansen and Evans<sup>1</sup> estimated that about 1,200 children are born with major craniofacial anomalies each year in the United States. This translates to about 20-25 cases per 5 million population base; thus, in Indiana, we would expect about 20 new cases a year. Most of these patients have normal intelligence or the potential for normal intelligence, so that successful rehabilitation becomes a high priority. With surgical advances over the last 15-20 years, it is now possible to offer these patients treatment that will, in many cases, allow them to assume a more normal role in society.

tistry; member, Craniofacial Anomalies Team. 
<sup>2</sup>Patient Care Coordinator, Pediatric Burn Unit, Indiana University Medical Center; member, Craniofacial Anomalies Team. 
<sup>3</sup>Assistant Professor of Surgery, Plastic Surgery Section, Indiana University School of Medicine; Assistant Professor of Oral and Maxillofacial Surgery, Indiana University School of Dentistry; director, Craniofacial

Assistant Professor of Oral and Maxillofacial

Surgery, Indiana University School of Den-

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Anomalies Team.

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Correspondence: Charles L. Nelson, D.D.S., Dept. of Oral and Maxillofacial Surgery, Indiana University School of Dentistry, 1121 W. Michigan St., Indianapolis, Ind. 46202.

## The Craniofacial Anomalies Team

The specialties represented on our Craniofacial Anomalies Team are:

Audiology Genetics Maxillofacial Prosthetics Neurology Neurosurgery Nursing Service Ophthalmology Oral & Maxillofacial Surgery Orthodontics Otology Patient Care Coordinator Pediatric Dentistry Pediatrics Plastic & Reconstructive Surgery Psychiatry Psychology Radiology Social Work

Anesthesiology

#### Anesthesiology

Speech Pathology

Surgery for craniofacial anomalies can present special problems in anesthetic management of the patient. Intubation can be difficult due to jaw anomalies that are often present. Because much of the surgery is intimately associated with the airway, maintaining airway patency during surgery can be difficult; thus, the anesthesiologist must conduct a thorough preoperative evaluation to examine airway management options. A tracheostomy is often done to ensure intraoperative and postoperative airway patency.

The following discussion provides an in-

sight into the role of each member of the

Craniofacial Anomalies Team.

Significant blood loss usually occurs in major craniofacial surgery. The anesthesiologist carefully monitors blood loss, with replacement of blood and fluid constituting one of his major responsibilities during the procedure. Frequently, a spe-



FIGURE 1: An 11-year-old boy with hemifacial atrophy (Romberg's Syndrome).



FIGURE 2: A 13-year-old girl with hypertelorism secondary to midfacial cleft.

cialized anesthetic technique—deliberate hypotension—is used to reduce blood loss.

Physiologic monitoring during surgery is also accomplished by the anesthesiologist. Bladder catheters are inserted to measure urinary output. A central venous line connected to a pressure transducer provides a continuous readout of central venous pressure. Cannulation of either the femoral or radial artery permits beatto-beat direct blood pressure monitoring and serial blood sampling for arterial blood gas tension determinations. Other essential monitoring devices include the temperature probe, electrocardiogram and precordial stethoscope.

In the postoperative period the anesthesiologist has primary responsibility for airway management and ventilatory support if it is needed.

### Audiology

The audiologist performs tests to iden-

tify any hearing difficulties. Hearing problems are not always recognized by either the parent or the child; however, when they are present and undetected, the result can be a delay in speech and language development, and poor performance in school.

Impedance measures (tympanometry and acoustic reflex studies) are made to evaluate middle ear function. These measures can contribute important information about the status of the middle ear and can often detect an otitis media when hearing test results are within relatively normal limits or show only a possible mild hearing loss. When hearing tests or impedance measures are abnormal, a referral is made to an otologist for an ear examination.

# Genetics

A genetic evaluation is usually accomplished on patients with craniofacial anomalies. It begins with an attempt to

establish a diagnosis, and the physical examination of the patient often yields findings characteristic of a specific disease or syndrome.

Once a diagnosis has been made, it is necessary to consider the genetic basis involved. To accomplish this, a detailed history relative to the pregnancy is obtained and exposure to known teratogens is ascertained. The latter includes drugs and other environmental agents. Next, a complete family history is obtained and the pedigree analysis completed. Family members, especially parents and siblings, are examined as indicated. Laboratory studies, such as chromosome analysis, dermatoglyphics, etc., are obtained as needed to help establish a genetic etiology.

Finally, when the disease, diagnosis and prognosis have been defined, genetic counseling is provided as a very important function of the geneticist. Both parents and the patient are vitally in-



FIGURE 3A: Frontal view of a 14-year-old boy with Pfeiffer's Syndrome, exhibiting hypertelorism and proptosis.



FIGURE 3B: Same patient in profile view emphasizing severe midfacial deficiency and proptosis.

terested in risk assessment relative to future offspring, and other family members who also may be at risk are often counseled.

The geneticist on our team also serves as coordinator of research projects carried out on patients seen by the Craniofacial Anomalies Team.

### Maxillofacial Prosthetics

The maxillofacial prosthodontist is a dental specialist who replaces, restores or rehabilitates oral/facial structures which may be missing or malformed. Non-living materials are used to restore and enhance the missing form and anatomy. This specialist fabricates ocular, nasal and auricular prostheses, and also constructs devices to rebuild or enhance facial or cranial contours. The maxillofacial prosthodontist has a commitment to the oral cavity and may make prosthodontic applicances throughout the patient's life. This commitment is especially manifested

in the rehabilitation of mastication, deglutition, speech and oral aesthetics.

### Neurology

Craniofacial anomaly patients have varying degrees of neurologic involvement. Central nervous system involvement is not uncommon in major craniofacial anomalies such as midfacial clefts. Cranial nerve involvement is also seen, especially in anomalies related to the first and second branchial arches such as hemifacial microsomia, where seventh and eighth nerve deficits are common. The neurologist, in conjunction with the psychologist, identifies any mental deficits which may be present.

Through the evaluation process, the neurologist is able to identify the extent of neurologic involvement for the craniofacial anomaly patient.

### Neurosurgery

The neurosurgeon is a vital member of

the Craniofacial Anomalies Team, performing the early craniectomies for patients with craniosynostosis. Also, patients who have one of the other craniofacial dysostosis syndromes often require cranial decompression, which the neurosurgeon performs.

Many of the corrective surgical procedures for craniofacial anomalies require a combined intracranial/extracranial approach. Examples include procedures for orbital translocation and some LeFort III procedures. In these cases the neurosurgeon is primarily responsibile for the intracranial component: performing the craniectomy, removing the frontal bone, exposing the anterior cranial fossa and replacing the frontal bone at completion of surgery.

### **Nursing Service**

Nurses with varying functions make valuable contributions to the Craniofacial Anomalies Team. They actively commun-

icate with each other and the other disciplines in passing on the special needs of each child and family. The focus of our nursing staff is total family involvement, not just treatment of the patient.

Our clinic nurses are interested in the child's general health status. They teach the parents special techniques in feeding and treating any other area of concern which may impair optimum growth and well-being. They initiate the pre-operative teaching and are especially adept at recognizing and intervening in any special needs of the family.

Many of our patients stay in the Parent Care Unit for the inpatient evaluation. The nurses on this unit make the process of numerous consultations and tests as tolerable as possible for the family. Continued family education and preparation for surgery are emphasized.

When the child is admitted for surgery, the unit nurses will continue the preparation process. The child may be in Pediatric Intensive Care for a relatively short stay postoperatively. Although parent visitation is limited, the nursing staff helps parents understand and follow the child's progress. After the child arrives back on the original unit, parents are encouraged to participate in their child's care. Home care instruction is initiated as soon as possible by the nursing staff to allow parents to become reasonably comfortable with the new care regimen. If professional home care follow-up is desired, referrals to community health agencies are made, preferably before the child is discharged.

The surgical nurses on our team are actively involved in surgical planning for the patients. They are familiar with the special equipment set-ups and sequence of procedures that provide for a smoothly run surgery. They also make themselves available to the child and parents to answer questions about the operating room.

### Ophthalmology

The ophthalmologist is responsible for the diagnosis and treatment of the ocular disorders frequently associated with craniofacial anomalies.

Many craniofacial anomalies have, as a part of their pathology, a misalignment of the visual axes so that the eyes point in different directions. Under these circumstances, a child must alternate from one eye to the other or suppress one eye to eliminate double vision. Suppression occurs automatically, but if it is unrecognized and untreated during the first few years of life, the result may be a permanent loss of vision in one eye from disuse. This loss of vision is known as amblyopia. Further, under these circumstances, a child cannot develop stereopsis, or true depth perception. Additionally, children with craniofacial anomalies may have compression of the optic nerves by the anomalous bone growth and development so that optic atrophy will compromise the function of the optic nerve with a reduction in vision.

Exposure of the eyes due to incomplete closure of the eyelids, with resultant irritation or ulceration of the cornea, also occurs with some of these conditions. Excessive drying, lack of adequate lubrication due to abnormal tear production or abnormal lid function may occur.

It is important to understand that not all of these conditions may occur in any one patient with craniofacial anomalies. Indeed, many patients need no special eye treatment. Nevertheless, the ophthalmologist will examine most of the patients evaluated by the Craniofacial Anomalies Team. Insofar as the child's age and condition will permit, a determination will be made of visual acuity, alignment of the eyes, presence or absence of stereopsis and condition of the internal parts of the eye and the optic nerves. The ophthalmologist will serve as the patient's advocate in the planning of surgery, with emphasis on protecting and preserving the visual functions. At any appropriate period in the patient's management, this specialist may be called upon to perform corrective surgery on the eye muscles themselves in order to better align the eyes. Generally speaking, this would occur after the facial bones have been appropriately realigned and would not be part of the initial procedure.

# Oral and Maxillofacial Surgery

The oral and maxillofacial surgeon evaluates all craniofacial anomaly patients for facial form and function and iaw position. Because these children often have gross skeletal malocclusions and significant alterations in maxillomandibular function due to deficient, absent or deformed jaw structures, the oral maxillofacial surgeon is actively involved in planning the reconstructive surgery, and works closely together with the plastic surgeon to restore facial form and function and jaw position. Depending on the particular anomaly, surgery may involve LeFort type midfacial osteotomies at the I, II or III level, mandibular osteotomies or occasionally surgery in both jaws.

The oral and maxillofacial surgeon also performs other oral surgery that may be required, such as tooth extractions and gingivectomies. When the anomaly involves a cleft palate, treatment includes bone grafting to the anterior palate and alveolous to provide continuity to the maxillary arch.

### **Orthodontics**

The orthodontist is primarily responsible for the description and quantitation of the facial skeletal deformities. Through use of cephalometric radiographs, precise measurements of skeletal patterns are made and related to the norm. The orthodontist's thorough knowledge of growth and development of the human facial skeleton makes it possible to analyze the measurements and show areas of abnormal growth as well as to predict, to a certain extent, future growth patterns.

To help in the analysis, the orthodontist makes study models of the teeth and jaws, which aid in diagnosis and also play a key role in planning any surgery to change jaw position. A complete set of diagnostic photographs is also taken for use by several team members in their evaluation.

Many of the surgical procedures performed on these patients involve repositioning of the jaws. In these cases the orthodontist provides stablizing and fixation appliances on the teeth. This



FIGURE 4: Members of the Craniofacial Anomalies Team discuss patient findings and treatment recommendations during one of their regularly scheduled conferences.

specialist may also be involved closely with the surgeons in planning the final occlusal relationship and constructing an acrylic interocclusal splint to serve as a guide and fixation device during surgery.

Finally, and perhaps most obviously, through the use of orthodontic applicances the orthodontist is involved in correcting tooth malpositions that may exist.

### **Otologist**

The otologist evaluates all patients with ear disorders. Many craniofacial anomaly patients, because of anatomic abnormalities, suffer various forms of ear disease. It is not uncommon, especially in 1st and 2nd branchial arch syndromes, to be missing various ear parts, including the ossicles of the middle ear. The otologist coordinates audiologic studies as well as any special studies that may be needed, such as temporal bone tomograms, to evaluate middle ear structures. Any middle ear surgery that is to be done is performed by this member of the team. Patients who are under anesthesia for some other purpose are often examined by the otologist, with pressure equalizing tubes being placed when indicated.

# **Patient Care Coordinator**

The patient care coordinator arranges appointments, maintains patient records and closely monitors the interaction of the

patient and family with the various team members.

When a patient is scheduled for a team evaluation, the coordinator arranges and coordinates the hospital admission and all consultation appointments while the patient is in the hospital. This in itself is a formidable task, since as many as 15 specialists may see the patient during a three- to four-day hospital visit. Because the hospitalization is so busy, and often a bit confusing to the patient and family, the coordinator meets with them prior to admission to explain our system and what to expect during the admission. This relieves much of the anxiety and fear that they may be experiencing.

The patient care coordinator often corresponds with health and school personnel near the patient's home to help provide continuity of care for our patients in the local community. The coordinator is the most convenient point of contact with our team for the patients, their families and health care practitioners outside the medical center complex.

### **Pediatric Dentistry**

Patients with craniofacial anomalies often have peculiar dental configurations and problems to which the pediatric dentist is particularly well attuned. The most obvious role is to provide comprehensive dental care for this special patient. Routine prophylaxis, fluoride treatment

and restorative dentistry procedures are accomplished on a regular basis. For craniofacial anomaly patients with clefts, the pediatric dentist constructs maxillary orthopedic devices and obturator appliances to aid in maxillary segment repositioning and molding and feeding. This member of the team is also active in longitudinal jaw growth studies in cleft patients.

#### Pediatrics

The pediatrician, often in conjunction with the patient's local pediatrician or family physician, is responsible for the patient's overall health maintenance. This specialist performs complete physical evaluations and helps assess the patient's physiologic suitability for surgery.

The pediatrician works closely with the geneticist in the initial evaluation of the patient to establish a diagnosis. Close attention is also paid to growth status and other appropriate developmental milestones. The pediatrician works closely with parents and nurses in teaching good feeding techniques in patients whose particular anomaly may compromise feeding.

### Plastic and Reconstructive Surgery

The plastic and reconstructive surgeon is director of the Craniofacial Anomalies Team and coordinates its activities. As patients are admitted for a complete work-up, appropriate consultations are requested and are analyzed. The plastic and reconstructive surgeon leads the discussion at conferences and elicits all treatment options for consideration.

This key member of the team is primary surgeon in cases of major reconstruction of cranial and facial bones. If intracranial surgery is anticipated, as in orbital translocation, the plastic and reconstructive surgeon works closely with the neurosurgeon. If jaw movement or reconstruction is involved, the oral and maxillofacial surgeon is intimately involved in a joint effort with the plastic and reconstructive surgeon.

### Psychiatry

The child psychiatrist is concerned with the development of children, their families, their environments and their strengths and weaknesses in cognitive, interpersonal, emotional, behavioral and social development.

The child psychiatrist tries to understand the processes of human development and the factors which get in the way of healthy developmental progress. This specialist is also interested in special skills and strengths that children use to deal successfully with stresses. Since craniofacial anomalies, with their physical disfigurements and frequent accompanying problems with hearing, vision and other normal functioning, place extreme stress on the child and family, the child psychiatrist will help the family and members of the medical team make the situation as comfortable as possible with regard to hospital visits and surgery. Other members of the team are also assisted by this team member in planning how best to communicate with the patient.

### Psychology

The psychologists see the craniofacial anomaly patient to perform various psychological evaluations. These include assessment of developmental progress, intellectual ability, academic achievement and behavior. Developmental and educational histories are reviewed. Consultation with the parent and school regarding educational and/or behavioral management is included.

Two to four hours of patient contact is usually required to complete the assessment and formulate educational plans. The evaluations usually take place when the patient is admitted for the complete Craniofacial Anomalies Team work-up, although they can be accomplished on an outpatient basis.

### Radiology

The radiologist interprets any radiographic studies the patient may need and suggests studies as indicated. Standard face and skull films are usually taken and, depending on the particular anomaly, tomograms of the face, orbits or temporal bone may be indicated. Computed tomography probably gives the most information for evaluation and treatment planning for craniofacial anomalies. The spatial relationships and incredible anatomic clarity seen in CT scans greatly enhance the surgeon's ability to plan a procedure.

At each conference of the Craniofacial Anomalies Team, the radiologist shows any radiographic studies the patient may have had and discusses significant radiographic findings.

### Social Work

During the initial clinic visit, the social worker will provide a psycho-social assessment of the patient and family, including pertinent developmental and social history, strengths, vulnerabilities, stress factors and coping skills. As problems and strengths are identified, plans for counseling and recommendations to medical staff will be made. The social worker, as an integral member of the Craniofacial Anomalies Team, will continue to inform medical and hospital staff of factors in the family situation that affect medical treatment.

The social worker will assist the family by making referrals to appropriate persons/agencies on the local, county and state levels. Careful guidance will be given to the family regarding financial resources for the patient's medical care in conjunction with the Patient Accounts Department.

During hospitalization, the social worker will provide supportive counseling and facilitate communication between the family and medical/hospital personnel. The social worker's focus will be to assist the family in coping with stress during and after surgery and to continue to assess and explore emotional factors involved in forming realistic expectations of outcomes to surgery, together with adaptation to body image.

# Speech Pathology

The speech pathologist functions essentially as a monitor of speech output. All speech sounds are carefully analyzed to determine deviations from normal. Note is taken as to whether the voice is hoarse, strained or breathy; and the quality of nasal resonance and the balance of nasal tones are determined. The speech pathol-

ogist also identifies any errors in articulating speech sounds that may make speech hard to understand.

If deviation in any of these areas is suspected, the cause is evaluated. Perhaps nasal imbalance can be explained by an unduly open or closed velopharyngeal airway, as determined by radiographic or ultrasound studies or by direct visualization with a fiberoptic pharyngoscope. Articulation errors may relate to habits as well as to anatomic deviations of the mandible, lips, tongue or teeth.

The speech pathologist will act as the patient's advocate in recommending surgical procedures that may enhance speech. To the extent that anatomic variations are corrected, the speech pathologist offers therapeutic options to enhance maturation of speech or to achieve satisfactory compensations in motor productions to make speech optimal.

### Admission for Evaluation

Patients with craniofacial anomalies are generally admitted to the hospital for a complete evaluation. While hospitalized, the patients usually stay on the Parent Care Unit, a unique setting at Riley Children's Hospital where the parents room in with the children and participate in their care. The rooms are furnished much as the child's bedroom at home might be and thus provide a more homelike, relaxed atmosphere.

This hospitalization typically lasts three to four days and is a very busy time for the patient. Appropriate laboratory and radiographic studies are obtained. For smaller children some form of anesthesia or sedation is often needed to obtain accurate, good quality radiographic studies. This is taken into account when scheduling the child for these studies. Appropriate members of the Craniofacial Anomalies Team see the child for a specialized evaluation. These specialized evaluations form the basis of the Craniofacial Anomalies Team conference which will follow within a few weeks.

# Craniofacial Anomalies Team Conference

Conferences of the Craniofacial

Anomalics Team are scheduled every six weeks. These conferences have two purposes: (Fig. 4)

- 1. To discuss diagnoses and derive integrated treatment plans for new craniofacial anomaly patients.
- 2. To periodically re-evaluate and monitor the treatment of patients under the care of Craniofacial Anomalies Team members.

Two to four new patients are generally discussed at each conference. The discussion typically begins with an appraisal of the genetics involved and, if possible, a specific diagnosis is made. The pediatrician provides information as to the overall health and physical status of the child. The psychiatrist and psychol-

ogist provide input as to the child's actual and anticipated emotional and intellectual development. The orthodontist analyzes and quantitates the facial skeletal anomaly. As the discussion continues, all members of the team discuss their findings and make treatment recommendations. Once all recommendations have been made, the sequence and timing of the various proposed treatments are discussed. From this discussion the integrated treatment plan is formulated.

After the meeting, a summary of each team member's recommendations is compiled, along with the integrated treatment plan, and this is discussed with the family and patient. Copies of the team's report are forwarded to referring practitioners

and anyone else who may play a role in the patient's care.

The treatment plan is not cast in stone. As situations change, patients are re-evaluated and treatment plans altered. Treatment is carefully monitored, and treatment results are critically discussed at the conference. The overall effect is that patients with complex craniofacial anomalies are provided with quality, integrated care.

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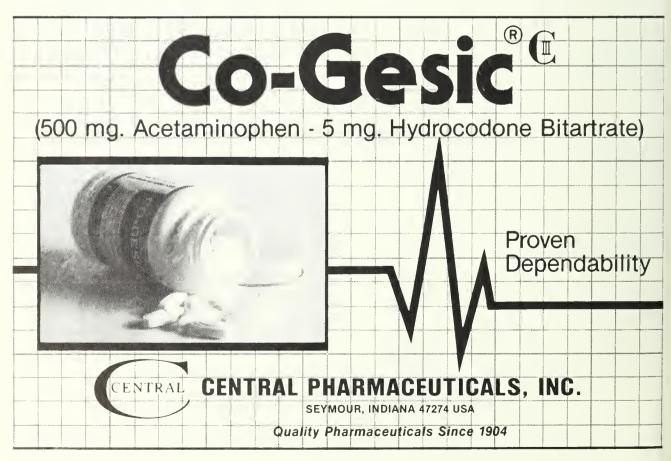
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# Clinico-Pathologic Conference: A 71-Year-Old Woman with Sudden Onset Dyspnea

Edited by DOUG REX, M.D. Indianapolis

**Dr. Rex:** A 71-year-old woman was admitted to University Hospital with sudden onset of severe dyspnea. She had been in her usual state of health until three weeks previously, when she developed a sense of fatigue and weakness. However, she was able to attend work every day. On the evening prior to admission, while at rest she suddenly developed severe dyspnea and orthopnea unaccompanied by chest pain, cough, sputum production, fever or chills.

The author is Chief Resident in Medicine, Indiana University Hospital W-587, 926 W. Michigan St., Indianapolis, Ind. 46223.

This is an edited transcript of the clinicopathologic conference conducted Sept. 5, 1984 during a Grand Rounds session of the Dept. of Medicine, Indiana University School of Medicine.

Discussants:

Harvey Feigenbaum, M.D., Dept. of Medicine;

Vernon Vix, M.D., Dept. of Radiology; Bruce Waller, M.D., Dept. of Pathology; Meredith Hull, M.D., Dept. of Pathology.

Dr. Feigenbaum is one of the world's foremost echocardiographers and is author of the textbook *Echocardiography*, widely regarded as the outstanding reference in this field. He has authored more than 170 papers in peerreviewed journals and currently serves on the editorial boards of six cardiology journals. He is founder and past president of the American Society of Echocardiography. In 1980 he was named Distinguished Professor of Medicine at the Indiana University Medical Center.

Seventeen years earlier a systolic murmur was noted. Three years later the patient was started on digitoxin, .1 mg per day, for mild dyspnea on exertion; however, there were no signs of overt congestive heart failure. Thirteen years earlier the diagnosis of Type II diabetes mellitus was made and caloric restriction was started. Two years prior to admission, treatment with 20 units of Lente insulin per day was added. I131 therapy for hyperthyroidism was given 16 years earlier and the patient subsequently required replacement therapy with thyroid extract. No other medications had been used during the month before admission.

Examination revealed an alert woman in respiratory distress. Respirations were 48, the pulse 130, the blood pressure 110/70 and temperature 37 °C. The fundi were normal. There was no jugular venous distention. The point of maximal cardiac impulse was displaced 2 cm to the left of the midclavicular line in the 6th intercostal space. There was a systolic thrill at the apex. A grade 4 holosystolic murmur was heard loudest at the apex and radiated over the precordium, neck and axilla. Her physician considered her murmur unchanged from previous exams. Rales were auscultated bilaterally in the posterior basilar lung fields, especially on the left. Mild peripheral cyanosis was noted and there was 1 + pitting edema at the ankles.

A chest x-ray showed blunting of the right costophrenic angle and bilateral infiltrates, worse on the left. An EKG showed sinus tachycardia, left anterior hemiblock and non-specific T wave changes.

The Hgb was 16.2 gm per 100 ml, the WBC 25,900 with 2% band forms, 83%

neutrophils, 9% lymphocytes and 6% mononuclear cells. The platelet count was 183,000. The sodium was 134 mmol/L, the postassium 4.7 mmol/L, the chloride 97 mmol/L, the bicarbonate 10 mmol/L, the urea nitrogen 34 mg per 100 ml, the creatinine 2.5 mg per 100 ml and the glucose 754 mg per 100 ml. An arterial lactate was 9.7 mEq/L; serum ketones were positive at a 1:2 dilution.

On 2 liters of oxygen per minute the pO<sub>2</sub> was 48 mmHg, the pCO<sub>2</sub> 28 mmHg and the pH 7.28. Hypoxemia and tachypnea persisted on high concentrations of inspired oxygen and thus an endotracheal tube was inserted and mechanical ventilation was initiated. On 100% inspired oxygen and 5 cm of positive end-expiratory pressure (PEEP) the pO<sub>2</sub> was 81 mmHg, the pCO<sub>2</sub> 32 mmHg and the pH 7.30.

A sputum gram stain showed no neutrophils and no organisms. The prothrombin time was 16 seconds with control 12.5 seconds. The partial thromboplastin time was 72 seconds with control 28 seconds. A fibrinogen level was 405 mg/100 ml, and fibrin split products were 40-80 mcg/ml. The Westergren sedimentation rate was 28 mm/hr. The urine sodium was 3 mmol/L and the sediment was normal.

A bolus of intravenous methylprednisolone was given and intravenous tobramycin, pipercillin and erythromycin were started. An insulin infusion was begun. The blood pressure deteriorated and large doses of intravenous norepinephrine were given to keep the systolic blood pressure greater than 90 mm/Hg.

A pulmonary artery catheter was placed. The right atrial pressure was 8 mmHg, the pulmonary artery pressure 49/21 mmHg, the pulmonary capillary

wedge pressure 24 mmHg, the cardiac index 1.76 liters/min/m², the systemic vascular resistance 1670 dynes•cm/sec⁵. In light of the hemodynamic data, norepinephrine was discontinued and infusions of dobutamine and sodium nitroprusside were started and diuretics were administered.

By the third hospital day there was modest improvement in the hemodynamics, the arterial lactate normalized, the chest x-ray improved and the urine output increased from 20 to 50cc/hr. The hyperglycemia was corrected and the coagulopathy reversed. On the fifth hospital day the pulmonary artery catheter was removed.

Four blood cultures and a urine culture were negative. A sputum culture grew a few non-group A B-hemolytic streptococci. The cytomegalovirus complement fixation titer was 1:32. A mycoplasma complement fixation was < 1:8 and Legionnaires IgG and IgM indirect fluorescent antibody assays were negative. A sputum direct fluorescent antibody smear for Legionella was negative. The creatine kinase rose to 364 IU/L with 100% MM band on isoenzyme fractionation. The lactate dehydrogenase rose to 438 IU/L and the isoenzyme fractionation showed the highest elevation in fractions 2 and 3. Serial electrocardiograms did not show changes of myocardial ischemia or infarction.

On the fourth hospital day a twodimensional echocardiogram was interpreted as showing a thickened mitral valve suspicious for vegetation, a calcified mitral valve anulus, a thickened aortic valve without significant aortic stenosis, a dilated left atrium and a hyperdynamic left ventricle. The left ventricular diastolic diameter was 3.7 cm, the left ventricular fractional shortening .24, and the left atrial diameter 3.4 cm.

From the fifth to eighth hospital days there was no improvement and progressive cyanosis of the extremities developed. Examination of the heart was unchanged and the patient remained afebrile. A second pulmonary artery catheter revealed a right atrial pressure of 12.5 mmHg, a pulmonary artery pressure of 40/26



FIGURE 1: An admission chest radiograph demonstrates bilateral pleural effusions and diffuse intraalveolar fluid, more dense on the left.

mmHg, a pulmonary capillary wedge pressure of 22 mmHg, a cardiac index of 1.73 liters/min/m² and systemic vascular resistance of 1709 dynes•cm/sec. 5 Dobutamine and sodium nitroprusside as well as broad-spectrum antibiotics were continued but her condition deteriorated. Anuria and eventually coma developed. She died on the 19th hospital day.

**Dr. Feigenbaum:** Dr. Vix, could you review the x-rays?

**Dr. Vix:** The admission chest radiograph (*Figure 1*) shows diffuse intraalveolar fluid, obviously much more dense on the left. The left heart border is partially obliterated. Both costophrenic angles are obliterated and there's an unusual contour to the right diaphragm suggestive of subpulmonic fluid. Thus, she has bilateral pleural effusions.

This chest film taken on the third

hospital day corresponds to her clinical improvement, at which time the intrapulmonary fluid has diminished but there is considerable increase in the bilateral pleural effusions. There is also a prominence along the left heart border that would correspond to some enlargement of the left atrial appendage. The endotracheal tube and a pulmonary artery catheter are properly positioned.

A chest film shortly before her death again reveals diffuse intraalveolar fluid, but in the right upper lobe and the left mid lung field there are infiltrates containing some air bronchograms.

**Dr. Feigenbaum:** Can you read infection on any of these films?

**Dr. Vix:** No. By "fluid" I mean this could be edema fluid, blood or exudate and from the appearance of the x-ray I can't make that differentiation.

**Dr. Feigenbaum:** In summary, we have an elderly female with a long history of a systolic murmur, insulin-requiring diabetes and thyroid replacement therapy after I<sup>131</sup> thyroid ablation for hyperthyroidism who presents to us desperately ill with profound dyspnea.

She initially manifests severe hypoxemia, pulmonary congestion, shock, hyperglycemia with some ketosis and coagulopathy. Our initial task is to determine the nature of her demise. The profound hypoxemia and pulmonary congestion suggest a primary pulmonary or cardiac process. The asymmetric alveolar infiltrates and the leukocytosis are consistent with severe pneumonia; however, several factors mitigate against this being the primary diagnosis. First, the patient is afebrile. In the absence of factors such as steroid therapy, uremia, or antipyretic treatment, the great majority of patients will manifest fever in response to pneumonia.1 Second, the sputum gram stain reveals no polymorphonuclear leukocytes and no organisms. This is very unusual in bacterial pneumonia<sup>2</sup> and coupled with the negative assays for Legionella suggests that the "sputum" was pulmonary edema fluid.

Another possibility is that the edema fluid might be the result of the adult respiratory distress syndrome (ARDS).3 The asymmetric pattern of the alveolar infiltrates and the bilateral pleural effusions are not typical, but can be considered consistent with ARDS. The history, however, does not suggest ARDS. The patient had the sudden onset of dyspnea. Generally, ARDS is precipitated by some already established serious illness, such as a pulmonary infection or hemorrhagic pancreatitis, or by some toxic event such as aspiration of gastric contents, exposure to irritant gases or drugs, or non-thoracic trauma with hypotension.3 We have no history of such an illness or event in this patient.

Gram-negative septicemia is a common cause of ARDS,<sup>3</sup> and the elevated WBC is suggestive of a serious infection. The physical and laboratory examination, however, including the negative urine and blood cultures, do not support gram-neg-

ative septicemia. Furthermore, as I will discuss, the hemodynamic data do not suggest sepsis. Therefore, I see little to implicate ARDS in this patient. The sudden onset of dyspnea suggests pulmonary embolus, but I exclude this diagnosis on the basis of the diffuse alveolar infiltrates, which would be quite atypical.<sup>4,5</sup>

This leads us to cardiac disease, which I believe is the primary etiology of the pulmonary infiltrates. The hemodynamic measurements indicate that her shock state is cardiac in origin. The cardiac index is low, 1.73 liters/min/m<sup>2</sup>, and the systemic vascular resistance is high. In septic shock we see just the opposite: a high cardiac index and a low systemic vascular resistance.6 The right atrial pressure is minimally increased and the pulmonary capillary wedge pressure is markedly increased, excluding hypovolemic shock, and reinforcing that cardiogenic shock is the problem. The major causes of acute cardiogenic shock and pulmonary edema are myocardial infarction, hypertensive crisis, cardiac arrhythmias and valvular heart disease.6

This patient had no chest pain and serial EKGs and isoenzyme fractionations failed to reveal myocardial damage, making myocardial infarction unlikely.7,8 In addition, the echocardiogram shows no segmental wall dysfunction, as is seen in acute myocardial infarction.9 Furthermore, there is no history of arrythmia and the blood pressure is low rather than high. This leaves valvular heart disease. There is an impressive and classic murmur of mitral regurgitation and this murmur is accompanied by a systolic thrill at the apex. The presence of an apical systolic thrill is a very reliable indicator of mitral regurgitation. The physical examination of the heart establishes mitral regurgitation and we suspect, but cannot confirm by physical exam alone, that this regurgitation is hemodynamically significant. There is no mention of giant V-waves in the wedge tracings. Were V-waves noted in this patient?

**Dr. Rex:** The original tracings were not available for me to examine but there was no mention in the physicians' notes of large V-waves in the wedge tracings.

**Dr. Feigenbaum:** The presence of large V-waves would confirm significant mitral regurgitation but their absence is not useful in excluding it.<sup>10</sup>

I believe the hyperglycemia, ketosis and coagulopathy are secondary phenomena. Ketoacidosis in the diabetic can follow any acute illness and certainly might be precipitated by the sudden onset of cardiogenic shock. The coagulopathy may be the result of a low-grade DIC, which may result from any shock state. 12

With this clinical impression in mind, we can consider the echocardiogram. The two-dimensional echocardiogram confirms profound mitral insufficiency. There are intense, bright echoes on both leaflets of the mitral valve, indicating the presense of masses of some type. Furthermore, these echoes can be seen slipping back and forth from the left atrium to left ventricle. Thus, this is clearly a flail, incompetent valve.

I believe these echogenic masses on the mitral valve leaflets suggest two possible etiologies of her acute mitral regurgitation: (1) bacterial endocarditis and (2) floppy mitral valve and ruptured chordea tendineae.13 I cannot distinguish these possibilities on the basis of the echo. If the diagnosis is bacterial endocarditis, then the masses represent vegetations. She had a prodrome of three weeks of fatigue and malaise, consistent with a "subacute" course of bacterial endocarditis. The white blood count was dramatically elevated with a slight shift to the left, suggestive of infection. The lack of fever is a major point against endocarditis. Fever has been reported in 100% of cases by some investigators, but others have reported normal or subnormal temperatures in 3 to 15% of cases. 14 However, a normal temperature pattern under reliable observation makes the diagnosis doubtful. The negative blood cultures are also against the diagnosis, but do not rule it out. Sometimes patients have received oral antibiotics for another diagnosis and the presence of these antibiotics in the blood may impair the growth of bacteria in culture media. If this is the case, blood for cultures should be injected into broth containing an antibiotic removal device.

This was not a problem in this case, since the patient had not received antibiotics prior to presentation here. However, even under the best circumstances 5-15% of endocarditis is "culture negative." My tendency is to over-diagnose endocarditis, and I never feel bad about this. I feel very bad when I under-diagnose endocarditis.

Several factors are consistent with a floppy valve (or mitral valve prolapse) with ruptured chordae tendineae.13 In this case, the intense echoes on the valve would represent areas of myxomatous proliferation on the valve. She had a systolic murmur for many years, which may have been a murmur of mitral valve prolapse. We can hypothesize that the onset of her malaise and fatigue may have been caused by rupture of a chordea tendineae, which is a well documented phenomenon in mitral valve prolapse.17 If the rupture was of a minor chordae it might produce only early symptoms of heart failure, such as fatigue and malaise. In this scenario her sudden deterioration prior to admission would be the result of further rupture of chordae, leading to massive incompetence of the mitral valve and profound heart failure. She had some improvement with appropriate treatment in the first few days, but further rupture of chordae tendineae, possibly at the tricuspid valve, led to her demise. This sequence of events is consistent with the clinical course and the echocardiogram, and must be a strong consideration in the differential diagnosis, in addition to bacterial endocarditis.

I would like to diverge to make two points. The first is regarding the use of norepinephrine early in her course to maintain blood pressure. Although I often used norepinephrine as a house officer to treat cardiogenic shock, it is now clear that this treatment is inappropriate. This is especially true with mitral or aortic insufficiency. In mitral insufficiency the ventricle can eject blood into the aorta or left atrium, and ejection occurs into the path of least resistance. Thus, if peripheral resistance is increased, then mitral regurgitation into the left atrium is increased. This decreases cardiac

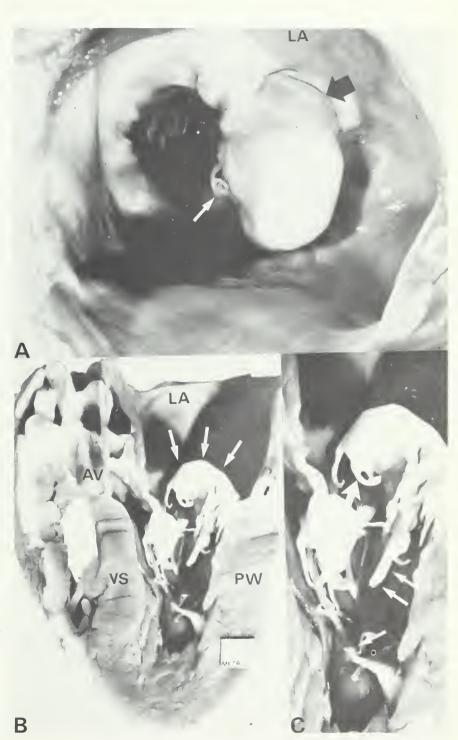


FIGURE 2: Floppy mitral valve with ruptured chordae tendineae. A. Left atrial (LA) view of prolapsed flail mitral valve leaflet (thick arrow) with associated ruptured chordae tendineae (thin arrow). B. Echo cut of heart showing flail mitral leaflet (arrows). AV = aortic valve, LA = left atrium, PW = posterior left ventricular wall, VS = ventricular septum. C. Close-up of flail leaflet showing remote calcified ruptured chordae (thin arrows) and recent noncalcified ruptured chordae (thick arrow).

output, which is just what we want to increase, and worsens the clinical situation.

Clearly, afterload reduction is what is needed when mitral regurgitation is present and, in fact, is indicated in most forms of heart failure. We have, for many years, treated heart failure with digitalis first, diuretics second and vasodilators third. In many cases, particularly with acute left ventricular decompensation, we should begin vasodilators earlier since they are very effective in increasing cardiac output.19 This patient responded well in the first few days to the combination of a vasodilator (nitroprusside), a strong inotropic agent (dobutamine), and diuretics. This treatment was appropriate and allowed stablization of her medical condition. However, it was no replacement for surgical therapy, which is clearly indicated when the valve is this diseased.

The second point concerns her clinical worsening on hospital day 5. A second pulmonary artery catheter was placed after this deterioration and the hemodynamic measurements are very similar to those obtained with the first study, except that the right atrial pressure rose from 8 mm Hg to 12.5 mm Hg. This 50% increase is clearly significant and suggests to me that the process affecting the mitral valve may have affected the tricuspid valve at this time. The resultant tricuspid insufficiency led to an increase in central venous pressure and a further increase in heart failure for which she could not compensate. My tendency would have been to obtain the first echo earlier than day 4 and then to get a second echo on day 5 or 6 at the time of her deterioration. This echo might have yielded valuable information regarding involvement of the tricuspid valve.

**Dr. Rex:** Dr. Feigenbaum's diagnosis, then, is heart failure secondary to acute mitral regurgitation. He considers the cause of the mitral insufficiency to be valvular destruction from endocarditis or mitral valve prolapse with rupture of chordae tendineae.

**Dr. Waller:** At necropsy (A83-041), the heart weighed 325 gm. Opening the left atrium disclosed a large segment of mitral

valve leaflet prolapsing into a dilated atrial cavity (*Figure 2*). The heart was cut in an antero-posterior longitudinal fashion, simulating a parasternal long-axis, two-dimensional echocardiographic view. Multiple chordae tendineae to anterior and posterior mitral valve leaflets had ruptured without evidence of active infective endocarditis. The mitral valve has an increased anulus (12.5 cm) and leaflet area (19.3 cm²) consistent with the morphologic diagnosis of floppy mitral valve.<sup>20</sup>

Superimposed upon the floppy valve condition were ruptured chordae tendineae (recent and remote), producing a flail mitral leaflet (*Figure 2*). Ruptured chordae from the anterolateral papillary muscle contained calcific deposits and the mitral valve anulus was also calcified (2+/4+). A corresponding transverse cut through the tricuspid valve disclosed a floppy tricuspid valve. The ventricular myocardium was free of necrosis and fibrosis, and the major epicardial coronary arteries had mild atherosclerotic plaques.

### Pathologic Diagnosis

- I. Floppy mitral valve (mitral valve prolapse) with multiple (recent and remote) ruptured chordae tendineae, producing a flail leaflet.
- 2. Floppy tricupsid valve (tricuspid valve prolapse).
  - 3. Mitral valve anular calcium.

### Discussion

**Dr. Waller:** Common causes of ruptured chordae tendineae are listed in *Table 1*. Of the nine causes listed, the most frequent etiology is active or healed

# TABLE 1 Causes of Ruptured Chordae Tendineae

- 1 Infective endocarditis
- 2. Floppy valves
- 3. Marfan's syndrome
- 4. Rheumatic heart disease
- 6. Anular calcium
- 7. Trauma
- 8. Myxoma
- 9 Idiopathic

infective endocarditis. The second most common etiology is floppy mitral valve syndrome. In the natural history of floppy mitral valves, spontaneous ruptured chordae tendineae producing sudden onset or increasingly severe mitral regurgitation occurs in about 7% of patients.21,22 Although the mechanism of chordal rupture in infective endocarditis is clear, the mechanism(s) for ruptured chordae in the floppy mitral valve syndrome remain(s) unclear.23,24,25 Postulates for rupture have included increased chordal tension from chronic prolapsing leaflets and associated chordal myxoid changes. In the present patient, associated calcific deposits in previously ruptured chordae tendineae may have caused additional chordae to rupture.

Normal chordae tendineae form an arcade of connections (primary, secondary, tertiary) from the papillary muscle (primary chordae) to the leaflet insertion (tertiary chordae). Rupture of one or more tertiary chordae is unlikely to cause significant clinical valvular dysfunction. However, rupture of multiple secondary or a single primary chordae may produce severe valvular dysfunction requiring valve replacement. In the patient described above, multiple ruptured secondary chordae produced a flail floppy mitral leaflet.

Dr. Hull: I will address the non-cardiac pathology. There were bilateral clear yellow pleural effusions suggestive of a transudative process. The lungs as expected showed tremendous congestion and edema with a combined weight of almost 2 kilograms. This is perhaps three to four times their normal weight. Some chronic changes were evidenced by the presence of hemosiderin in the interstitial spaces. There was some interstitial fibrosis associated with a non-specific chronic inflammatory infiltrate but no evidence of an acute pneumonia. The kidneys revealed tubular degeneration consistent with acute tubular necrosis.

**Dr. Rex:** This woman was poorly understood during her hospitalization. The fact that the murmur was unchanged from previous exams prior to admission

was probably misleading, and the echocardiogram was not interpreted as diagnostic of mitral regurgitation. Her physicians felt that pneumonia was contributing to her deterioration, and acute mitral insufficiency was never recognized as the primary problem.

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# Acute Tubular Necrosis and Minimal-Change Glomerulopathy Associated with Fenoprofen Therapy

SISIR K. DHAR, M.D. MOONAHM YUM, M.D.

■ENOPROFEN CALCIUM (Nalfon®) is a nonsteroidal anti-inflammatory drug derived from propionic acid, increasingly used for arthritides. It has properties similar to those of aspirin and has been regarded as a safer drug than aspirin. Recently, a few patients were reported to have developed renal failure and the nephrotic syndrome, apparently secondary to fenoprofen administration. Renal biopsies showed minimal-change glomerulopathy and interstitial nephritis. 2-5 We present two additional patients who, following fenoprofen therapy, developed reversible acute renal failure and the nephrotic syndrome and whose biopsies demonstrated minimal-change glomerulopathy and acute tubular necrosis rather than interstitial nephritis.

### Case Report #1

A 52-year-old white woman was admitted in February 1979 with a history of nausea, vomiting, and pedal and periorbital edema. She had been taking fenoprofen calicum 300mg to 900mg a

From the Dept. of Medicine, Union Hospital, Terre Haute, Ind., and the Dept. of Pathology, Indiana University Medical Center, Indianapolis, Ind.

Correspondence: Sisir K. Dhar, M.D., 615-8th Ave., Terre Haute, Ind. 47804.

### Abstract

We describe two patients who developed reversible acute renal failure and the nephrotic syndrome following fenoprofen therapy. Renal biopsy showed minimal-change glomerulopathy and acute tubular necrosis whereas previous authors found interstitial nephritis in association with fenoprofen administration. Recognition of the spectrum of tissue injury associated with this increasingly prescribed drug may prevent a more serious complication such as papillary necrosis.

day intermittently for one year for metacarpophalangeal joint pain and left shoulder pain. There was no prior history of renal, collagen-vascular disease, hypertension, upper respiratory tract infection or skin infection.

On admission her blood pressure was 140/100 mm Hg. Her urinary output was 800-1000 ml per 24 hours. Laboratory studies showed blood urea nitrogen (BUN) 96 mg/dl, creatinine (Cr) 11 mg/dl, Serum Na 129 meq/L, serum calicum 7.9 mg/dl, phosphorus 7.5 mg/dl, albumin 2.5 g/dl with total protein of 5.3 g/dl. Urinalysis showed 3 + protein, many red cells and few granular and hyaline casts per high power field but no eosinophils. A 24-hour urine contained 25 g of protein.

A complete blood count (CBC) was normal and sedimentation rate was 54 mm/hour. The following investigations were normal or negative: serum protein electrophoresis, immunoglobulin, antinuclear antibody, rheumatoid factor, serum complement, sonogram of kidneys,

and chest x-ray. She stopped taking fenoprofen at the time of admission.

The patient was initially treated with peritoneal dialysis, and a percutaneous renal biopsy was performed five days after admission. Following the biopsy, the patient was treated with oral prednisone 60 mg/day with decreasing dosage for eight weeks with disappearance of proteinuria and stabilization of renal function (BUN/Cr 16/1.9 mg/dl). Two years after discharge her renal function remained stable without any proteinuria.

### Case Report # 2

A 77-year-old woman with no prior history of collagen-vascular or renal disease was admitted in March 1980 with nausea, vomiting and oliguria of three weeks duration. She had a history of essential hypertension for about nine years. Hypertension was controlled with Chlorthiazide. For six months she had been on fenoprofen calcium 300mg to 900mg a day intermittently for her back pain due to osteoarthritis.

On admission the patient was lethargic and confused. Examination revealed a blood pressure of 190/80 mm Hg, 3 + pedal and periorbital edema, and presence of pericardial friction rub. Laboratory studies showed BUN/Cr 144/22 mg/dl, serum potassium 6.7 meq/L and serum albumin 3 g/dl with total protein 5.3 g/dl. Urinalysis showed 4+ protein, with no casts or eosinophils.

The following investigations were normal or negative: ANA weakly positive at 1/25, serum complement (C3,C4), serum protein electrophoresis, immunoglobulin, rheumatoid factor, anti-glomerular basement membrane antibody, hepatitis-associated antigen, and ultrasound of the

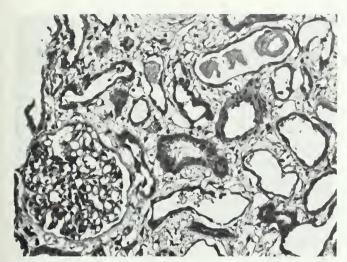


FIGURE 1: Light microscopic appearance of renal biopsy (Patient 1). Note tubular necrosis, extensive interstitial edema and the absence of inflammatory cell infiltrates (H&E X160).

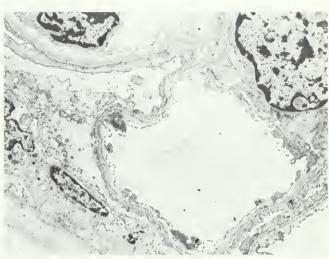


FIGURE 2: An electron micrograph of glomerular capillaries showing an extensive effacement of foot processes, without electron dense deposits in the mesangium or on the basement membranes (X7,000).

kidneys.

She was treated with intermittent hemodialysis and prednisone 60 mg/day with decreasing dosage. Percutaneous renal biopsy was done three weeks after the admission. The patient's renal function gradually improved over the following eight weeks. Two years after discharge her BUN/Cr stabilized at 18/0.8 mg/dl with normal urinalysis.

### **Pathologic Findings**

Renal tissues were examined by light, immunofluorescent and electron microscopy. On light microscopy, both patients showed normal glomeruli and acute tubular necrosis with interstitial edema but no cellular infiltration (Fig. 1). Immunofluorescence was negative for immune deposits. Electron microscopy revealed diffuse effacement of epithelial foot processes without dense deposits, consistent with minimal change glomerulopathy (Fig. 2).

### Comments

In these two patients, acute renal failure and the nephrotic syndome developed following the administration of fenoprofen, and subsided after withdrawal of the drug. This temporal relation strongly suggests a cause-and-effect relationship between the fenoprofen

therapy and renal complications.

Renal biopsy in both patients showed minimal-change glomerulopathy and acute tubular necrosis. Our findings are at variance with others in which allergic interstitial nephritis was incriminated for similar renal complications. <sup>2-5</sup> Common findings of drug-induced interstitial nephritis, such as fever, skin rash, and eosinophilia, were absent in our patients.

Most of the nonsteriodal anti-inflammatory drugs including fenoprofen have the capacity to inhibit the enzyme cyclooxygenase and thereby inhibit the production of prostaglandins.6 Since prostaglandin inhibition is known to reduce glomerular filtration rate, this may be the mechanism by which acute tubular necrosis is induced in the fenoprofen therapy. The mechanism by which the drug causes minimal-change glomerulopathy and thereby the nephrotic syndrome is not clear. It is, in fact, paradoxical, considering the fact that nonsteroidal anti-inflammatory drugs are known to reduce proteinuria in the nephrotic patients.8

Our findings suggest a diversity of renal lesions and emphasize the potential reversibility of these complications associated with fenoprofen therapy. Recognition of these facts by the clinician and pathologist may prevent a more serious complication,

i.e., papillary necrosis that may occur, as reported by Husserl, et al.9

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# Prescription Fluoride: An Update for Indiana Physicians

VICTOR H. MERCER, D.D.S. Indianapolis

RESCRIPTION FLUORIDES for children were discussed in an article published in the *Journal of the Indiana State Medical Association* in June 1981. This current article serves to update the information provided at that time concerning the uses and precautions of prescribing supplemental fluorides.

The Indiana State Board of Health established a water analysis program in 1978 to assist Indiana dentists and physicians in determining the fluoride content of their patients' drinking water. The program, known as W.A.F.F., is intended to help practitioners who wish to prescribe systemic fluoride for their patients. At present, more than 300 dentists and physicians have made use of the program, and about 100 samples are reviewed by the State Board of Health each month.

The need for the W.A.F.F. program was determined on the basis of: 1) the considerable number of children ages 0-13 on private water supplies, and 2) the still fairly considerable number of children of the same ages residing in nonfluoridated communities. (In reference to the latter, approximately 95% of the state's drinking water from a community source is or will soon be receiving optimum fluoride

through the water). A recent survey by the Dental Division, Board of Health, revealed great variability in the natural fluoride level of private water supplies. This was true on near or even adjacent properties as well as where traditionally high or low fluoride areas of the state were known to exist.



Dr. Mercer

The Council on Dental Therapeutics of the American Dental Association classifies sodium fluoride as an acceptable dietary supplement and lists a number of accepted preparations in the form of tablets, liquids and drops. Brand names are most useful when using preparations for infants. Fluoride tablets may be designated simply as sodium fluoride tablets.

Recommendations and precautions for the use of fluoride supplements are as follows:

1. Because dietary fluoride works via

systemic utilization, it should be administered from 6 months of age until 12-13 years, when the crowns of the teeth are completed.

- 2. The dental benefits to expectant mothers have not been adequately demonstrated, so prescription fluoride is not recommended during pregnancy.
- 3. Prescription fluoride should be used only where the drinking water is 0.7 ppm. fluoride and below. The following prescription may be used when the child is 3 years or older and the water fluoride 0 to 0.2 ppm. It should be noted that 2.2. mg. sodium fluoride contains 1 mg. fluoride.

Sodium fluoride tabs 2.2 mg. D.T.D. no. 120 Sig: One tablet per day to be chewed and swished before swallowing.

- 4. For the child 2 years of age, the prescription can be changed to 1.1 mg. sodium fluoride tablet or one-half of a 2.2 mg. tablet (again assuming water fluoride is 0 to 0.2 ppm.) See table (item 9 below) for variations.
- 5. For children 6 months to 2 years, one 2.2 mg. tablet may be dissolved in one quart of water and used for formulas and cooking. If more convenient, proprietary sodium fluoride drops or liquids may be used for this age group. Some better known acceptable infant preparations are: Fluoritab (Fluoritab Corp.); Flura-Drops (Kirpman Tabs); Karidium (Lorvic Corp.); Luride Drops (Hoyt Tabs); and Pacemaker Solution (Pacemaker Corp.).
- 6. When prescribing sodium fluoride, do not prescribe more than a four-month supply at one time. This assures that not more than 264 mg. (2.2 mg X 120 days) sodium fluoride will be in the home. Each package should bear the statement: Caution—store out of reach of children.

The author is Director of Preventive Dentistry for the Dental Division, Indiana State Board of Health; and Associate Professor, Dept. of Preventive Dentistry, Indiana University School of Dentistry.

Correspondence: Division of Dental Health, Indiana State Board of Health, 1330 W. Michigan St., Indianapolis, Ind. 46206.

- 7. Although there is sufficient evidence of the effectiveness of vitamin-fluoride preparations, these should be used in general for children 3 years and older and where the water fluoride is 0.0-0.2. This is because of the fixed preparation of ingredients in vitamin-fluoride preparations.
- 8. There is no contraindication for children receiving prescription fluoride to also receive *topical* fluoride treatments from their dentist. For caries-active children, administering both topical and systemic fluoride represents good preventive dentistry. A fluoride mouth rinse may also be used topically, especially where there is a caries problem. The use of a fluoride dentifrice is always recommended. Children may also participate in

school rinse or brush-in programs using fluoride topical preparations.

9. The table below may be used to determine prescription dosage:

Supplemental Fluoride Dosage Table\*
(in mg. fluoride per day) according to
fluoride in drinking water.

	Concentration of fluoride in water (ppm)			
Age	0-0.2	0.3-0.7	0.7 or greater	
0-2	0.25 mg.	0	0	
2-3	0.50 mg	0.25 mg	0	
3-13	1.00 mg	0.50 mg.	. 0	

\*convert 1 mg of fluoride to 2.2. mg. sodium fluoride in writing prescription

The W.A.F.F. program works as follows: I) send a check for \$50 to the Water Laboratory, Indiana State Board of Health, 1330 W. Michigan St., Indianapolis, Ind. 46206, and request I0 prepaid W.A.F.F. kits; 2) 10 plastic bottles and protective preaddressed boxes will be sent to you; 3) patients may be given the W.A.F.F. kit (instructions are enclosed) and may mail the box to the Board of Health; 4) fluoride analysis information will be returned to you and the patient or however you specify; and 5) you handle your own charges with the patient.

### REFERENCE

 Blankenbaker RG: Public Health Notes: Administration of fluoride supplements. J Indiana State Med Assoc, 74:382, 1981.

# **Nutrition Update: Sugar**

The following summary is reprinted from the July-Angust 1984 issue of "Dairy Conncil Digest," a newsletter devoted to the review of recent nutrition research. This summary is reprinted by conrtesy of the National Dairy Conncil.

Our current intake of refined sugars often is blamed for a number of health problems such as obesity, micronutrient deficiencies, behavioral disorders, diabetes mellitus, and dental caries. While consumption of refined sugars is greater today than at the beginning of this century, it has remained relatively stable over the past 60 years. In fact, intake of some sugars such as sucrose has decreased.

There is no evidence that sugars per se contribute to obesity or micronutrient deficiencies. Likewise, there is little scientific support for claims that sugars cause various behavioral and learning disorders. Such claims tend to be based on anecdotal observations or correlational studies rather than on controlled, randomized, double-blind trials.

Intake of sugar does not cause adultonset diabetes mellitus despite some assumptions to the contrary. Although the specific etiology of diabetes is unknown, excess energy intake leading to obesity appears to be a major determinant. Recent studies suggest a more liberal use of refined sugars in the dietary management of diabetics, particularly those who are not overweight.

There is considerable evidence that carbohydrates, and in particular sugars, contribute to dental caries. However, there is no direct relationship between the amount of sugar in a food and its ability to induce caries. Both the frequency of sugar intake and its consistency (e.g., stickiness) determine the cariogenicity of a sugar-containing food. Moreover, fluoride, dental hygiene, and protective factors in food can modify sugar-induced dental caries.

Recently, some cheese have been shown to decrease the cariogenicity of sugar.

The "optimal" or "safe" level of refined sugars in the diet is unknown. Individuals may need to limit sugar consumption if it interferes with the adequate intake of other nutrients or maintenance of proper energy balance, or if it is consumed in such frequency or form, or at such times to encourage development of dental caries.

In terms of dental caries, it is best to limit sugar intake to meal time.

# Who Should Go to Medical School?

LDER PHYSICIANS are often asked such questions as "Should my son or daughter try to enter medical school? Can you help him or her to be admitted? How much will it cost? What specialty, if any, would it be most appropriate to choose?" Less often, it is the potential candidate himself who asks these questions.

If it is the parents who first seek advice, I am reluctant to give my own views until I have seen and talked to the young person in question.

In my opinion the single most important consideration is the depth of the genuine desire of the young man or woman to enter the medical field and the commitment in time and energy he or she is prepared to make to achieve it. Sustained enthusiasm, the capacity for hard work and a certain amount of discipline are essential.

Also, a few facts of life should be understood. Unless grades in high school and college have been higher than average, admission committees are unlikely to go deeply into the other factors which might make the applicant an acceptable candidate. These committees do pay attention to exceptional circumstances. Letters from prominent persons in a community who are family friends understandably emphasize the positive qualities of the applicant with little on the negative side. More attention is paid to letters of former high school and college teachers of the applicant who can and often will give them factual appraisals of the young persons being evaluated. Letters from family physicians usually are taken seriously. Much attention is given to each candidate's performance in the College Admissions Test.



PAUL S. RHOADS, M.D. Richmond

The average number of applications made by prospective students to medical schools is about 10. In 1981, 36,000 students applied for 17,000 places in the freshman classes of the 121 medical schools in this country. Obviously a great many well qualified students are turned down, especially by the more popular schools.

Also, medical education is expensive. A bulletin received recently from the Council on Medical Education of the American Medical Association<sup>2</sup> quotes a report of the American Association of Medical Colleges. It indicates that, for 1982-1983 first year medical students, the *average* annual cost for tuition and fees for those in private medical schools was \$11,063 and for living and other expenses \$7,147, making a total of \$18,210. For public medical schools (presumably state and city financed) the tuition and fees annually averaged \$3,163 and other ex-

penses \$6,464 if they were living within the jurisdiction—total \$9,628. For nonresidents attending the public schools the figures were \$6,605 and \$6,465, respectively, for a total of \$13,070.

Report P of the Board of Trustees of the AMA (1983) indicated that the educational debt of 1982 graduating medical students averaged \$18,994 for graduates of public medical schools, with 82.3% having some debt, and \$24,214 for graduates of private schools, with 84.0% having some debt.

Most families cannot finance the medical education of their offspring. Somewhat over 80% of medical students require loans. Families that earn less than \$30,000 a year are eligible for federal loans of \$5,000 a year at 9% interest. Some of those earning more than \$30,000 are also eligible if the funds are needed after a "required family contribution" based on income and family size.2 Such funding for a promise of a certain period spent in the armed services is still possible. Similar arrangements for a commitment to practice in some rural areas where physicians are badly needed may be offered by some states. How long this partial aid will last is very uncertain.

Fortunately, times have changed regarding the financing of the postgraduate years. Most hospitals accredited for this kind of training pay residents annual stipends of \$12,000 to \$18,000. In the present economic climate these salaries are most likely to go down rather than up, but almost surely will not go to zero as was usually the case in the first third of this century.

Given the practical considerations outlined above (there are others) the ultimate decision to try for medical school should depend upon what the candidate perceives as the most important goals and rewards of a medical career. To fulfill the dreams and hopes of a devoted and often sacrificing family is surely a worthy goal;

Dr. Rhoads is Director of Continuing Medical Education, Reid Memorial Hospital, Richmond, Ind., and Professor of Medicine, Emeritus, Northwestern University.

but if in his innermost consciousness the prospect of a medical career has no particular allure for him he had better think twice before making his decision just to please the family. If the appeal of medicine as a calling does not go beyond that, he will have an unhappy time as a physician. Most young people will tell you they wish to choose a profession in which they will directly help their fellow human beings. I am sure most of them are sincere in this. If they prove to be good doctors they can fulfill this goal in a variety of ways, depending upon what their talents and personal philosophies may be.

Let us consider some of them:

·Direct contact with patients. Sometimes physicians can prevent and cure disease. They nearly always can give pain relief and offer other remedies to make life more tolerable. This is a major goal worth striving for. However, practicing physicians have another and sometimes more important role than that. A useful doctor must be an interested and devoted friend, willing to listen to a patient's troubles, give helpful suggestions about things other than physical disorders that are making life uncomfortable, always creating the feeling that "we are in this thing together" and helping if he can. This heart-to-heart contact between the doctor and his patient is for me the best part of all. If one can get them to admit it, most doctors who deal directly with patients feel the same way.

•Clinical research. The search for new facts and truths is a fascinating facet of medicine without which no progress could be made. Seeking and learning in a comprehensive search what has been accomplished in a given limited field, then working diligently to extend somewhat the knowledge in that field, for some people, proves an exciting venture. At the same time the discipline required to work in an orderly way and report one's findings honestly is rigid. This, one must have

to succeed in any field of medicine.

•Teaching. All physicians must be teachers. Those in practice have the obligation to explain what they think are their patients' medical and emotional problems and the reasons for what treatment is prescribed. Other physicians become teachers in medical schools and derive immense satisfactions from their careers. Some teach medical science at the preclinical levels, others hold clinics and do bedside teaching to students in small groups. Full-time teachers are expected to carry on research also. Usually their commitments in time and energy are as great as those of their counterparts in solo or group clinical practice.

•Standing in the community. The era in which doctors held a position of respect just because they were physicians is about over. Such prestige is still bestowed by their patients and fellow citizens if it is earned. To earn it the doctor must, of course, have hard-nosed competence in his given field. Beyond that, if he is to merit the respect that some practitioners conceive as their right, he must be honest, compassionate and in turn respectful of the persons and pocketbooks of those he serves.

•Financial security. This is important but the *least* important of what should be the goals of the young physician. A comparable amount of time and energy spent in many other fields can produce more income. The effort and discipline required to be a good doctor deserve a much more satisfying reward than money.

The diversity of the careers open to a person who has been trained in medicine adds to the profession's appeal. In addition to those mentioned above, opportunities present themselves in public health work (wholesale vs. retail medicine); administration (practically all medical school deans and many university presidents are physicians); church-sponsored foreign mission and ghetto

medical work; writing and editing; positions as medical officers in the military and business corporations. The ways in which a physician may serve his fellow men are almost endless. There are always outlets in which to channel his energies for any physician depending upon his natural abilities and turn of mind.

It must be emphasized again that none of the careers mentioned above is an alternative to being a competent physician, well trained in the facts and skills of his calling. First of all, he must learn how to recognize disease and prevent and cure it at the level now reached by the best practitioners of the profession. Also, to have joy in his work he must be a caring physician who believes his patient is entitled to the best he has to give, including sympathy and understanding. Ofter he can and does combine two or even three of the career opportunities open to him. Private practice combined with part-time teaching in a medical school is an example. Denied the contributions of part-time teacher-practitioner, no school could offer well-rounded medical education. And many would have a hard time surviving financially.

Above all, to find satisfaction in his daily tasks, whatever form they may take, personal integrity and a high sense of responsibility toward the patient's welfare and toward his own ideals is necessary. Good doctors must be good men and women.

### REFERENCES

- 1. Undergraduate Medical Education. *JAMA*, 246:2913-2930, 1981.
- 2. Report A (1-38) of the Subcommittee in Cost and Financing of Medical Education and Availability of First Year Residency Positions to the Council on Medical Education of the American Medical Association, Dec. 4-7, 1983.
- Report of the Board of Trustees, American Medical Association, A-83, June 19-23, 1983.

# Marketing Uses of Public Relations

HE QUESTION of advertising by individual doctors and physicians has been an issue for almost a decade. Yet, years after Supreme Court and Federal Trade Commission rulings set aside restrictions against advertising by professionals, controversy continues unabated about such uses.

Historically, restraints on advertising were instituted to protect a medically unsophisticated public from falling prey to the unscrupulous. Even today, years after promotion became an issue, so strong is the suspicion of an alliance between advertising and purely selfish motives that its employment can still stigmatize the user.

These circumstances present the medical profession with a new challenge: to evolve methods of expanding its channels of communication with an information-hungry public without transgressing reasonable ethical guidelines. The situation calls for methods that provide the public with responsible information and at the same time preserve respect for the dignity and standards of conduct of the medical profession. One such acceptable method is public relations.

# Differences Between Advertising and Public Relations

While both advertising and public relations are powerful aids in helping shape public perceptions and attitudes, there are some basic differences in reader-response to them. Both advertising and public relations deal in information. While the purpose of information in advertising is to induce a desire to buy, in public relations, information is used primarily to promote good will and understanding.

Space in which advertising appears is



ART STEVENS New York

purchased; public relations space is not. Advertisers exert almost total control over the information they present in the purchased space, and the amount of information presented is limited by cost alone. On the other hand, control of public relations information rests with the media and is presented only when it meets rigid media criteria of newsworthiness or beneficial public information. Consequently, because PR information is filtered through newscasters, reporters and editors, these third-party reports seem more objective and therefore often more believable.

# Growing Public Hunger for Medical Information

Despite the fact that self-promotion efforts raise some eyebrows within medical circles and prompt discussion of appropriate ethical guidelines, the trend toward such promotion has been growing steadily for several years. This has happened because the public is eager for more medical information.

In response to this emerging public appetite, all the media have expanded their coverage of medical facts and developments. This circumstance has made it possible for farsighted medical people to utilize the situation effectively. By making it part of their professional duty and responsibility to engage in providing the public with reliable, comprehensible, upto-date information, they enlighten the public and simultaneously promote themselves.

# Public Relations Methods Vary Widely

Public relations offers a variety of opportunities to engage in this process: Guest appearances on discussion shows on radio and television; "how-to" books on medical subjects; guest editorials on specific health- or fitness-related topics; articles authored by or quoting a medical professional; syndicated health and fitness columns; participation as speakers in local groups and meetings where issues related to medicine may be part of the agenda.

Each of these activities provides a needed public service. In addition, each represents a powerful way of increasing public awareness of a specific physician and that individual's expertise. Such opportunities are having a profound influence on how professionals can build and enlarge their practices. Compared to these uses of the media, the old hanging-out-a-shingle-and-listing-oneself-in-the-Yellow Pages lacks impact. And waiting for word-of-mouth referrals takes many years.

# What to Expect from Public Relations

Responsible PR professionals have guidelines that enable them to help medical specialists market themselves honestly. If you use public relations help, you can rightly expect the following:

Mr. Stevens is president of Lobsenz-Stevens, Inc., a New York public relations firm. Address: 460 Park Avenue South, New York, N.Y. 10016.

- 1. Your name before a wide public. Public relations can achieve enhanced recognition quickly and associate your name with a specific set of skills.
- 2. Public awareness of your view-point, outlook, expertise.
- 3. A balanced campaign employing national, regional and local exposure, as appropriate to your objectives.
- 4. A systematic campaign with a timetable, written plan, set of themes for articles, scheduled interviews and regular progress reports. These make it possible to monitor results.
- 5. Ongoing interaction with your agency.
- 6. Identified objectives well suited to your marketing needs. These needs will vary as specialties themselves vary. For example, if the specialty is otolaryng-

ology, the PR campaign might include:

- •An article in a national consumer publication such as *The Saturday Evening Post* on "Hearing Impairment: Who Is At Risk?"
- •An article in a national consumer publication such as *Time* or *Business Week* on "How To Counter Negative Public Attitudes Toward Hearing Loss."
- •Appearances on TV programs—national or local—to discuss the latest diagnostic and surgical procedures in hearing loss treatment.
- •Releases to health/medical editors of national women's, men's and general interest magazines, large circulation daily newspapers and news syndicates on treating hearing loss.
- •Speaking engagements to reach specific regional groups dealing with hear-

ing loss: the elderly, high risk groups in industry, etc.

These examples illustrate how a PR campaign can reach a national audience, a specific local group or both. It can gain attention, educate, alert, inform—and achieve these tasks effectively and responsibly.

Health care providers employing public relations can expect to become much better known and to be sought after by people who are in need of the precise medical services they provide. Moreover, these activities can bring honor, recognition and credit both to themselves and to their colleagues. At the same time the entire marketing effort can be accomplished in an ethical, dignified, professional manner.

# An Ounce of Prevention

Suggestion: When involved in the care of a patient with other physicians, make sure that there is a clear delineation of responsibility for overall management of the patient's condition.

Discussion: Extracted from a case file: Patient goes to ER complaining of chest pains. As a favor to the private physician, ER doctor writes orders that will at least get the patient admitted to the floor. Next, floor contacts the private physician to apprise him of circumstances, giving him ample time to make any changes or additions to the ER doctor's initial orders—he did not.

Early the next morning, the patient became very ill. Nurses notified house doctor. House doctor looked in on patient, did nothing, wrote no orders and left. The patient died. What happened? Who is responsible?

•ER Doctor—could have admitted patient to ICU or at least ordered monitoring of V.S. and Defense recommendation prepared by the Medical Liabil-

ity Mutual Insurance Company, New York, N.Y.

EKG on the floor, but did not. His orders were incomplete. He *assumed* private physician would follow-up.

- •Private Physician—could have corrected incomplete orders of ER doctor, but he didn't inquire further into patient's condition beyond the information he received from the floor's initial phone call to him. He *assumed* that if the situation was "serious" the house doctor would have written proper orders for patient care.
- •Nurses—contended that they couldn't do anything that wasn't ordered and since orders for this patient were sketchy at best, they did nothing. They assumed house doctor would address the problems.
- •House Doctor—could have made further contact with private physician to elicit instructions for patient care, but did not. He looked at the orders, saw they were incomplete and did nothing. He assumed private physician was aware of the seriousness of the situation and would follow-up on patient care.

# New Winona Sleep Center offers full sleep medicine capabilities

As the list of identifiable sleep-related disorders grows, so does the need for corresponding diagnosis and treatment centers.

To assist in the diagnosis of disorders such as sleep apnea syndromes, excessively loud snoring, insomnia, and narcolepsy, and the less frequent conditions of sleep paralysis and nocturnal myoclonus, there is a need for a fully operational sleep-disorders program. Sound, practical, and cost-effective consultation, overnight sleep study, treatment, and follow-up can be found in the Sleep Disorders Center.

The Center, located at Winona Memorial Hospital, utilizes the expertise of physician consultants experienced in sleep-disorder medicine, a fully equipped

lab/bedroom area, and the skills o specially trained technicians.

Patients are accepted into the program primarily through physiciar referral. Evaluations, test interpreta tions, and follow-up recommendations are sent to the referring physician.

The program is completed on a outpatient basis, and fees ar reimbursable through insuranc carriers. Fees are charged for medic consultation, pre-study testing, slee studies, and subsequent visits. A list the current fee structure is availab upon request.

The telephone number for patie scheduling at Winona's Sleep Di orders Center is 927-2100. Inquiri about sleep-disorder medicine a invited.

Conditions evaluated at the Sleep Disorders Center

Sleep Apnea Syndromes (adults and children)

Loud Snoring

Excessive Daytime Sleepiness (EDS)

Narcolepsy

Insomnia

Sleep Problems in Chronic Lung Disease

Male Sexual Dysfunction (Nocturnal penile tumescence)

Seizure Disorders including Nocturnal Epilepsy

Sleep Paralysis

Hypnagogic Hallucinations

Nocturnal Myoclonus

Sleep Walking (Somnambulism)

Night Terrors (Pavor Nocturnus)

Restless Legs Syndrome (Ekbom's Syndrome)

Organic Brain Syndromes (affecting sleep)

Kleine-Levin Syndrome

Toxic Metabolic Syndromes (affecting sleep)

Some Nocturnal Pain Syndromes which disturb sleep

### **CONSULTANTS:**

Frederick A. Tolle, M.D.

Medical Director

Sleep Apnea Syndromes

Ramon S. Dunkin, M.D.
Sleep Apnea Syndromes

Michael W. French, M.D. Neurological Disorders

Norman W. Oestrike, M.D. Neurological Disorders

Kenneth N. Wiesert, M.D.
Insomnia and Sleep Disorders

Winona Memorial Hospital



Member, Association of Sleep Disorder Centers

# Motrin reduces inflammation, pain ...and price

# New low price...major savings

The dramatic reduction in the price of Motrin Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

# Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of Motrin Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with Motrin Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of Motrin Tablets continue to be available by prescription only.

Please turn the page for a brief summary of prescribing information.

# Motrin 400

Good medicine...good value

Motrin" Tablets (ibuprofen)

**Contraindications:** Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close super vision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets **Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever. As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other

nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

**Drug interactions.** Aspirin. used concomitantly may decrease Motrin blood levels. Coumarin. bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** *Motrin* should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions:** The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but tess than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,\* epigastric pain,\* heartburn,\* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence): Central Nervous System: Dizziness,\* headache, nervousness; Dermatologic: Rash\* (including maculopapular type), pruritus; Special Senses: Tinnitus; Metabolic/Endocrine: Decreased appetite; Cardiovascular: Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%-Probable Causal Relationship\*\*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests, Central Nervous System: Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma, Dermatologic: Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia, Special Senses: Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAU-TIONS); Hematologic: Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit, Cardiovascular: Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; Allergic: Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis; bronchospasm (see CONTRAINDICATIONS); Renal: Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria, Miscellaneous: Dry eyes and mouth, gingival ulcer, rhinitis

Incidence less than 1%—Causal Relationship Unknown\*\*

dastrointestinal: Pancreatitis: Central Nervous System: Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri, Dermatologic: Toxic epidermal necrolysis, photoallergic skin reactions, Special Senses: Conjunctivitis, diplopia, optic neuritis; Hematologic: Bleeding episodes (e.g., epistaxis, menorrhagia), Metabolic/Endocrine: Gynecomastia, hypoglycemic reaction, Cardiovascular: Arrhythmias (sinus tachycardia, sinus bradycardia), Allergic: Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; Renal: Renal papillary necrosis.

\*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

\*\*Reactions are classified under "Probable Causal Relationship (PCR)" if there has been one positive rechallenge or if three or more cases occur which might be causally related Reactions are classified under "Causal Relationship Unknown" if seven or more events have been reported but the criteria for PCR have not been met

**Overdos age:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain. 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription.

MED B-7-S

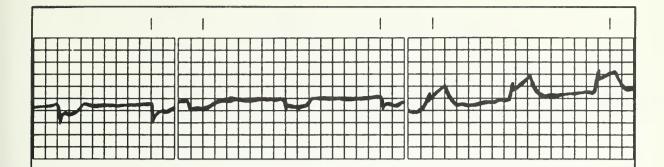
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The Upjohn Company Kalamazoo, Michigan 49001







# This misread EKG delayed the patient's admission & treatment—and cost the doctor a malpractice claim.

The doctor who read this EKG diagnosed the patient's nausea as being due to gastroenteritis and sent her home. Six hours after being admitted the next day, the patient expired of an acute MI.

The result: A malpractice claim against the physician.

Recent national evidence, and information from our own claims files, suggests that MIs are frequently misdiagnosed. The EKG above, for example, strongly indicates an acute MI.

We know that insurance coverage alone won't solve the malpractice problem. It will also take reasonable patient expectations. And even greater diligence by physicians.

That's why our medical directors review hundreds of cases each year. Their jobs: To spot problem areas or emerging trends and warn policyholders, through timely publications, medical/legal seminars and other educational presentations.

So if you're looking for thorough insurance protection *PLUS* valuable information on avoiding potential malpractice traps, look into coverage from Pennsylvania Casualty Company.

See your insurance agent/broker, or contact us at the address below.



# PENNSYLVANIA CASUALTY COMPANY

Suite 506 / 3737 North Meridian Street / Indianapolis, IN 46208 / (317) 926-5836

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# Steps to a Healthier, Happier New Year

This is the time of year when many of us stop to reflect on our lives and how we could change them for the better. When your thoughts turn to plans for a healthier, safer 1985, consider adopting the New Year's resolutions for better health offered by the American Council on Science and Health. Here they are:

#### 1. Don't Smoke

If you don't smoke, don't start.

This should be Item #1 on any list of health-related resolutions. Cigarette smoking is the leading cause of preventable death in America. Some 340,000 American smokers die each year of smoking-related diseases.

By not smoking eigarettes, you're protecting yourself from an enormously increased risk of lung cancer, one of the least treatable types of cancer. You're decreasing your risk of heart disease, bronchitis, emphysema, cancers of the mouth, throat, pancreas, and bladder, and (according to one recent study) the flu. You're also less likely to set your house on fire if you don't smoke, which is no small consideration. Smoking was responsible for more than \$300 million in fire damages in 1981. Most of these fires occurred in residential buildings, where nearly 2,000 people died and more than 3,000 were injured.

If you do smoke, make this the year that you kick the habit. It *does* pay to quit, even if you've smoked for many years. For information on how to stop smoking, contact your local American Cancer Society office or the government's Office on Smoking and Health, Park Building, 5600 Fishers Lane, Rockville, Md. 20857.

### 2. Don't Mix Drinking with Driving

Fifty thousand people die in the U.S.

From the American Council on Science and Health, 1995 Broadway, New York, N.Y. 10023.

each year in traffic accidents. Half of these deaths are attributable to alcohol. This carnage is particularly tragic because the individual who dies may not be the one responsible for the accident, and because these deaths are preventable.

Resolve not to mix drinking with driving this year! It's no disgrace to call a cab if you've had one too many; it's good common sense. We also like the National Highway Traffic Safety Administration's slogan: "Friends don't let friends drive drunk." That attitude could help to save many lives.

### 3. Adopt a Sensible Diet

Are you on a diet? Twenty million Americans are on what they consider a "serious" weight-loss diet at any given time. Yet many people don't take weight control, or diet in general, seriously enough.

Few subjects have accumulated as much incorrect and potentially dangerous folklore as the subject of weight control. While it's true that being *significantly* overweight can be harmful to your health, few people realize that unwise dieting can also be hazardous.

For instance, the popular Atkins diet has been condemned by many authorities as a medically unsound regimen. Many doctors think that the best thing about the Scarsdale Diet is that dieters are told not to stay on it for more than two weeks. The Beverly Hills Diet has made people seriously ill with diarrhea and dehydration. The Cambridge Diet, sold door-todoor, and similar products sold in stores, are very-low-calorie regimens of a type that should only be used under close medical supervision, yet people are buying and trying these diets on their own. At the end of 1983, the Cambridge Diet was losing some of its popularity, but other very-low-calorie formula diets were still selling well, and often being misused. Some people even seek out weight-loss products that have been banned because they are hazardous. For instance, the FDA banned the once-popular starch blockers in 1982, because they had not been proven safe or effective, yet many people were still trying to buy them in 1983, and some less-than-ethical retailers were selling them.

We're not trying to discourage you from tackling that unwanted blubber. But when you do it, stick to a reasonable, gradual diet and exercise program, and check it out with your doctor before you start. You have more to lose than a few pounds.

Diet and nutrition, in a more general sense, are important to your health even if you're not trying to lose weight. Moderation and variety are the keys to good nutrition. Dietary extremes, on the other hand, can be a real hazard. A good example of this was reported in 1983, when doctors discovered that the cause of the mysterious neurological symptoms experienced by seven patients was overdosing on vitamin B6. This vitamin had previously been regarded as non-toxic, but at the very high dosages that these patients were consuming-more than a thousand times the U.S. Recommended Daily Allowance—vitamin B6 caused serious damage that may not be completely reversible. Other nutrients that can be dangerous in excess quantities include vitamins A and D, and many of the essential minerals.

# 4. Exercise Regularly, but Exercise Caution

Many medical experts are now convinced that physical fitness *does* matter, in terms of overall health and life expectancy. Lack of exercise is one of the factors that can increase your risk of coronary heart disease, which is responsible for more deaths in this country than any other illness. The current surge of interest in exercise is healthful. We hope you're

among the 70 million Americans who are participating, and we hope you're doing it reasonably.

"Reasonable" means realizing that it will take some time to get back into condition after years of sedentary living. You can't expect to keep up with experienced runners, skiers, bikers, or swimmers right away. Once you are in shape, some experts believe that for the physically well-conditioned person, appropriate moderate exercise for a period of 30 to 60 minutes three or four times a week is beneficial in reducing heart attack risk.

Aches and minor injuries are to be expected in any sports or fitness program. Common sense dictates that any injury that isn't truly trivial deserves professional medical attention.

# 5. If You Drink Alcohol, Do It in Moderation

We already warned you about the dangers of mixing alcohol with gasoline. Here, we'd like to mention a few other alcohol-related risks. Safety is an important consideration. Your ability to swim, ski, use power tools, drive a boat, etc., is affected if you've had more than one or two drinks, so be cautious.

There is clear evidence that long-term excessive use of alcohol is harmful. In addition to the obvious problem of alcoholism, it's also associated with cirrhosis, other liver diseases, and disorders of the heart and nervous system.

On the other hand, absolute abstinence from alcohol is *not* necessary to protect your health. In fact, people who drink moderately seem to have a *lower* risk of heart attacks than people who don't drink alcoholic beverages at all.

# 6. Have Your Blood Pressure Checked

It doesn't even hurt, you know.

High blood pressure is a common problem, and an important one, because it increases the risk of strokes, heart attacks, and kidney failure, *if* it is left untreated. That's the bad news.

The good news is that there's clear evidence that effective treatment of high blood pressure reduces the risk of these serious complications. One *conservative* estimate suggests that better detection and

treatment of high blood pressure could save 8,800 lives a year in this country.

Two things stand in the way of saving these lives. First, high blood pressure often has no symptoms, which is why it's called the "silent killer." So have your blood pressure checked this year, and ask your doctor how often you should have it checked in the future.

Second, some people who have high blood pressure don't follow the prescribed treatment program. If you're one of them, you should realize that in order to reduce your risk of serious complications, it's important to follow your doctor's instructions, even if you feel great. It's inconvenient, but it pays off in the long run.

### 7. Use Seat Belts, Every Time

Automobile safety belts can reduce traffic deaths by 50% and injuries by 65%, if they're used. So buckle up every time, even for short drives. There's no good substitute for the protection provided by your lap and shoulder belts, not even the much-publicized air bag. Safety belts protect you in all collisions, while air bags only work in frontal collisions, which make up only 20% of all crashes. Safety belts are 5.5 times more effective in preventing fatalities than air bags are, and 2.4 times more effective in preventing injuries. Regardless of whether the government decides to require air bags in new cars, you'll still need to buckle up for

# 8. Make Sure There's a Working Smoke Detector in Your Home

Residential fires are the second most frequent cause of accidental death in the home, claiming as many as 8,000 lives a year. Many of these deaths occur because too much time elapsed before the fire was detected.

Smoke detectors could reduce the home fire death toll by 40% or more, *if* everyone used them. So if you don't already have a smoke detector, it might make a good New Year's present for your family.

If you already have a smoke detector, take a minute today to find out if it's working. Do the batteries work? Did you

put the batteries *back* in the detector after you created a "false alarm" by burning those hamburgers? Does everyone in your household know what the smoke alarm sounds like, and what to do when they hear it?

# 9. Be a Cautious Consumer of Health Information

As Americans have become more interested in good health, there has been an increase in the availability of health information in books, magazines, and newspapers, and on radio and TV. Unfortunately, a great deal of this health advice is unsound, and some of it is dangerous. For instance, in a few cases, people have been killed or permanently harmed by very high doses of vitamins and minerals—doses that were recommended by popular "nutrition" books. More commonly, people damage their health by following self-treatment advice in selfhelp health books, instead of seeking urgently needed medical treatment.

Many people believe, *incorrectly*, that health information can't be published or reported on radio or TV, unless it has been proven true. But authors, editors, and broadcasters are under no legal obligation to prove that their statements about health are accurate. In fact, it is perfectly legal for them to publish material which has been *proven false*. The First Amendment to the U.S. Constitution, which guarantees freedom of the press, also guarantees Americans the right to spread *mis*-information about health.

So "shop" as carefully for health advice as you do for everything else. Don't believe everything you read or hear. Try to find reliable sources of health advice.

# 10. Focus Your Efforts on Things that Matter

If our present knowledge of disease prevention were fully applied, health in this country could be improved, and the average life expectancy of Americans could be extended. The means by which this could be accomplished are not very complicated: good medical care and the kind of common-sense living emphasized in our first nine resolutions could do the trick.

# EDITORIALS

# Doctor/Patient 'Contract' Guest Editorial

Since beginning my practice of medicine I have always felt that a contract was made between a physician and a patient when the physician and patient accepted their relationship as doctor/patient. This relationship has been well established for millenia and the ethical and legal foundation for it remains sacred to physicians. I feel certain that most, if not all physicians, treat their patients to the best of their ability regardless of the payment potential of the patient.

For this reason, a recent communication from one of the major insurers in this country was shocking to me. Its sole purpose appears to be the intrusion of a fiscal agent into this special doctor/patient relationship. This insurer has introduced what they euphemistically call a hospital Preadmission Certification/Continuing Stay Review which they state "combines our benefits expertise to create a utilization review procedure with significant cost saving potential." It is also stated that this program is national in scope.

The significant portion of the letter deals with the submission of a long form to a company for certification prior to admission of a patient. It also will require employees of companies which enroll in this program to participate, in order to receive maximum benefits—the implied threat being that if patients refuse to comply, they will not receive maximum benefits. At no time is the quality of care

THE RUM

"I'm a very busy man. How long will it take you to find out what's wrong with me?"

mentioned and there is no proof that this approach will lower costs. In fact, the "Second Opinion" programs, which were introduced years ago in Connecticut to save money on hospitalization, have failed abysmally. Now the insurers have taken a new tack which to me, is blatant interference by a fiscal agent into the doctor/patient relationship which should not be tolerated by either party. In fact, such interference might even be illegal although I am certain that the law department of this major insurance carrier has looked into the legality of this program and has concluded that no laws have been or will be broken.

If this arrangement is legal then it remains up to us as physicians, as well as our patients, to attempt to alter this policy. What right has an insurance company to determine whether a patient should be hospitalized, the type of service to be rendered or the setting in which this service is performed? These are medical decisions and these corporate behemoths have no rights in this regard. Their concern should be only with reimbursement for quality care.

It behooves everyone of us to start talking to our patients, explaining that their insurance company, whose premiums are being paid for by the hard labor of employees and only through the employers, and strongly suggest that this approach will not be tolerated. We must all approach employee groups such as unions and inform them of this callous interference into benefits earned with their minds and bodies.

1 suspect that every physician in the state has received this correspondence and I would suggest that it be read and a personal plea be formulated to be used on the part of every one of us, to our patients, indicating this gross and callous interference into our relationship of trust with our patients. As 1 see it, if the program fails, the cost of running it will be added to health care costs and used as an indication that these costs are increasing. If it succeeds, my crystal ball suggests that soon we may all require "cookbooks" dispensed by payors outlining norms of treatment from which deviation will not be tolerated. The quality of care will be compromised, services will of necessity be rationed and in time, the disincentives

may lead to mediocrity in our noble profession.

Please talk with your patients and try to maintain this time honored and sacred doctor/patient relationship—Joseph S. Sadowski, M.D., president, Connecticut State Medical Society. Reprinted with permission from the September 1984 issue of Connecticut Medicine.

# Legislative Uniformity

Uniform Law Commissioners, a confederation of state commissions on uniform laws, is drafting a legislative proposal that could bring uniformity to natural death laws. The ULC is also drafting legislation that would help states protect confidentiality of medical records and give patients more control over how their health-care information is used. The recommendations will be presented to state legislatures.

Crucial and legally important differences among state laws, and the complete lack of laws in some states, produces a legal climate that makes it difficult to protect basic rights. The computerization of medical records, especially hospital charts, makes it highly desirable to establish a uniform code.

# The Pap Smear

A very interesting and encouraging clinical report in a recent issue of JAMA confirms that the Pap smear has reduced the incidence of invasive cervical cancer by as much as 75%<sub>0</sub>.

The study was conducted by Bjorn Stenkvist, M.D. of the University Hospital in Uppsala, Sweden. The clinical investigation followed 207,455 women for 10 years.

The 75% decrease occurred among women who had Pap smears at least once in 10 years. Among those who never had Pap smears, the incidence of invasive cervical cancer was four times as great as among those who had been examined at least once.

When women were screened at least once, the incidence of cervical cancer dropped from 32 in 100,000 to 10 in 100,000. Among women with at least one normal smear, the incidence dropped still lower, to seven in 100,000.



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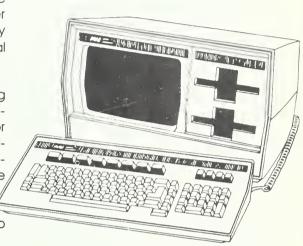
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# AUXILIARY REPORT

Judy Koontz (Mrs. James A.) President, ISMA Auxiliary

To extend their personal greetings to you in the spirit of the season, the following past presidents and members of the Board of Directors, ISMA Auxiliary, have contributed to the AMA Education and Research Foundation:

Judy Koontz Muriel Osborne Alfrieda Mackel Vivian Priddy Anne Throop Dorothy Bickers Martha Stout Mary Jo Gutwein Hulda Classen Karen Schleinkofer Ellaine Cox Joann Wehlage Charlotte Bennett Marge Smith Susie Ferguson Lura Stone Sue Greenlee Suzanne Miller Helen Snyder Carole Wainscott Jackie Kalsbeck Barbara Lukemever Linda Kinman Joanne Tharp

May Peace, Joy and Happiness be yours this Christmas Season





Rosanna Iler (Liaison) Marianna Irwin Helen Fargher Chloe Goldsmith Mary L. Johnson Betty Kephart

# Peace on earth

Yi Kintner Mazo Scales Dorothy Schiller Sylvia Schneider Bea Shields Mary K. Stanley

# The Holiday Sharing Card: What's It All About?

This Auxiliary project is the most widely used item to date for raising AMA—ERF funds. Many county and state auxiliaries, as well as the National Auxiliary, participate.

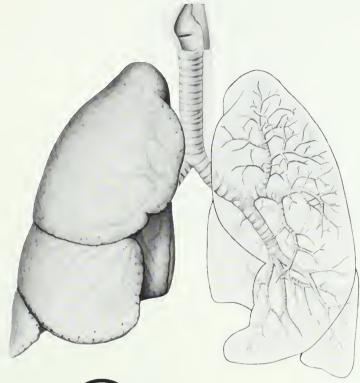
The Sharing Card reaches every medical family of the participating organization whether or not the spouse is a member; therefore, everyone becomes acquainted with the program. The "sales pitch" is that we don't need to in-

dividually send cards to each other; the Sharing Card wishes ALL a "happy holiday"—and we are performing a service for the Auxiliary. Many physicians want to be included on Sharing Cards.

Contact your local auxiliary if you would like to make an annual contribution to AMA—ERF by participating in the Sharing Card program. If the cards aren't available locally, ask that the project be considered for next year.

Best wishes and peace on Earth to you and yours.—Judy Koontz

# **Consider the** causative organisms...



# cefacior cefacior

250-mg Pulvules t.i.d.

# offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, H. influenzae, S. pneumoniae, S. pyogenes (ampicillin-susceptible) (ampicillin-resistant)

Briet Summary Consult the package literature for prescribing information

indications and Usage Cector (cetaclor Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms. Lower respiralory infections, including perimonia caused by Streptococcus pneumonia (Diplopoccus pneumonia). Palemophilus influenzia, and S. progenes (group A beta-hemolytic streptoccus).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cector

Contraindication Cector is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Contrandication Cector is contraindicated in patients with known altergy to the cephalosporin group of antibotics.

Warmings. IN PENICILLIN-SENSITIVE PATIENTS. CEPHALO-SPORIN ANTIBIDITICS SHOULD BE ADMINISTERED CAUTIOUSLY HERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL ROBOSS. ALLERGENICITY of THE PENICILLINS. AND THE CEPHALOSPORINS. AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS. INCLUDING MANAPHYLAXIS. 10 BOTH ORDIC CLASSES.

TRIBUTES IN CLINICAL WARD CONTRAINED FOR THE PROPERTY OF THE

ment should include sigmoidscopy, appropriate bacteriologic studies, and fluid, electricityte, and protein supplementation. When the colitic does not improve after the drug has been discontinued, or when it is severe, oral viacomycin is the drug of choice for antibution; associated besudomentionaus colitics produced by *C attache*. Other causes of colitis should be truded out.

produced by C difficile. Other causes of colitis should be ruled out.

Precautions General Precautions—If an allergic reaction to Cector "cleator, Littly occurs, the drug should be discontinued and, if necessary the patient should be treated with appropriate agents, e.g. pressor annies, annihistannes, or controsteroids. Profonged use of Cector may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombis tests have been reported during treatment with the complatosporn antibotics. In hematologic studies men with the complatosporn antibotics in hematologic studies are performed on the minor side or in Coombis Testing of newborns whose mothers have received cephalosporn antibotics before parturation, it should be recognized that a positive Coombis Test may be due to the drug.

Cector should be administered with caution in the presence of markedly impared renal function. Under such conditions, careful clinical observation and laboratory studies should be made anxiety of the course. The course of the course is the course of the cour

colitis
Usage in Pregnancy — Pregnancy Category B — Reproduction
studies have been performed in mice and rats at doses up to 12
limes the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fortility or harm to the fetus due to Cector 'certactor, Lilly.' There are however, no adequate and well-controlled studies in pregnant women. Because an interpoduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. \*\*Musray Mothers\*\*—Small amounts of Cector have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.16, 20, 20, 21, and 01 flamcy mild show, three, four, and five hours respectively. If ace amounts were detected at one hour five reflect on nuising infants is not known rursing woman. \*\*Usage in Online\*\*—Salety and etterviewess of this product for use in inlants less than one month of age have not been established \*\*Afwers Reactings\*\*. Affects considered related in brazing.

Usage in Children—Safety and effectiveness of this product for use in inlants is set han one month of agine have to been established Adverse Reactions. Adverse effects considered related to therapy with Cector are uncommon and are listed below. Gastrointestimal symptoms occur in about 2.5 percent of patients and included diarrhed. In 701. Symptoms of pseudomembranous collists may appear either during or after antibiotic treatment. Nauses and vomiting have been reported rarely hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbitiom expitions II in 100 percent of patients and include morbitiom expitions II in 100 percent of patients and include morbitiom expitions II in 100 percent of patients. Cases of setum sickness-like reactions reythema multiforme of the above skin manifestations accompanied y arthritis arthraligia and, frequently, fever it have been reported These reactions are apparently due to hypersensitivity and have usually occurred during of following a second course of therapy with Cector Such reactions have been reported more frequently includent hair in adults. Signs and symptoms usually occur are days after initiation of therapy and subside within a few days after cessation of therapy has displayed in enhance resolution of the symptoms.

occurred in patients with a history of penicillin allergy *Other* effects considered related to therapy included eosinophila (1 in 50 patients) and gential printlus or againsts (less than 1 in 100 patients). The control of the cont

Note: Cector\* (cefactor, Lify) is contraindicated in patients with known allergy to the cephalosporins and should be given cauthously to pencultin allergor, patients.

Pencultin is the usual drug of choice in the treatment and prevention of steroptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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# CME QUIZ

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: Indiana University School of Medicine, CME Division, Fesler Hall 224, 1120 South Dr., Indianapolis 46223.

# **Breast Cancer**

# CONTINUED FROM PAGES 935-939

- 1. Which of the following is the most important pair of prognostic factors in patients with breast cancer?
  - a. Steroid receptor analysis and patient age
  - b. Patient age and axillary lymph node status
  - c. Axillary lymph node status and steroid receptor analysis
  - d. Menopausal status and a histopathologic diagnosis of medullary adenocarcinoma
- . Tumors lacking steroid receptors are associated with all of the following excent:
  - a. Long doubling times
  - b. Tendency to metastasize to brain and liver
  - c. Early recurrence following primary therapy
  - d. Lack of response to hormonal manipulation
- 3. Which one of the following increases the risk for developing breast cancer?
  - a. Late menarche
  - b. Early age of first childbirth
  - c. Birth control pill usage
  - d. A positive family history

- 4. Adequate primary therapy for a patient with a small primary tumor (less than 2 cm) with no axillary node involvement would *not* include:
  - a. Modified radical mastectomy
  - b. Extended radical mastectomy
  - c. Quadrantectomy and radiation therapy
  - d. Lumpectomy and radiation therapy Which one of the following patients would be most likely to benefit from ad-
  - juvant combination chemotherapy?

    a. A postmenopausal woman with stage

    IV disease
  - b. A postmenopausal woman with negative axillary lymph nodes and a steroid-receptor-positive primary
  - c. A premenopausal woman with 3/17 positive axillary lymph nodes
  - d. A premenopausal woman with a primary tumor greater than 5 cm in size
- Present day adjuvant chemotherapy is based on all of the following principles except:
  - a. Microembolic tumor foci occur as a result of primary surgery and must

- be eradicated
- b. Micrometastatic disease develops during the natural history of breast
- Micrometastatic disease can be eradicated with chemotherapeutic agents effective against gross metastatic disease
- d. Primary therapy successfully debulks the majority of tumor cells present in the patient.
- 7. Which one of the following statements about adjuvant therapy is true?
  - Adjuvant chemotherapy should be given to all axillary-node-negative patients with steroid-receptor-positive primary tumors
  - Adjuvant hormonal therapy is safe and has proven efficacy in prolonging the overall survival of steroidreceptor-positive patients
  - Adjuvant therapy probably prolongs the disease-free survival of most patients, and may prolong overall survival in some patients
  - d. Adjuvant chemotherapy is associated with a 5% mortality rate due to infectious complications.
- 8. In the postmenopausal patient with a steroid-receptor-positive tumor and multiple metastases to the lung, the current preferred treatment is:
  - Thoracotomy and wedge resection of metastases
  - b. Radiation therapy to tumor-involved areas

CONTINUED ON PAGE 978

# NOVEMBER CME QUIZ Answers

Following are the answers to the CME quiz that appeared in the November 1984 issue: "Sexually Transmitted Diseases," by Robert B. Jones, M.D.

1. d 6. a 2. c 7. b 3. b 8. b 4. b 9. c 5. a 10. b

inswer sh	eet for	Quiz:	(Breast	Cancer)	
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 1. a b c d
 6. a b c d

 2. a b c d
 7. a b c d

 3. a b c d
 8. a b c d

 4. a b c d
 9. a b c d

 5. a b c d
 10. a b c d

I wish to apply for one hour of category I AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of Indiana Medicine for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for this month's quiz, send your completed, signed application before Jan. 10, 1985 to the address appearing at the top of this page.

# NEWS NOTES.

# **ACSM Completes Move**

The National Center of the American College of Sports Medicine moved into its new headquarters in Indianapolis last month.

The 19,000-square-foot facility is located at 401 W. Michigan St., Indianapolis. It will be used for conferences, information collection and dissemination, continuing education and certification programs, and board/committee meetings.

The college moved to Indianapolis from Madison, Wisc., last year.

# For the Asking . . .

•Reusable specialty medical products are listed in a 1984-85 catalog published by Popper & Sons, a major supplier of reusable specialty products. The fully illustrated catalog details such items as reusable glass syringes, needles and thermometers. For a copy, write Popper & Sons, Inc., Dept. RP, 300 Denton Ave., New Hyde Park, N.Y. 11040.

• "Making Prospective Payment Work" is a two-part videotape series produced by the American Medical Record Association. The first videotape, "Physicians and Documentation," features a discussion between a physician and a medical records professional regarding documentation practices required of physicians to ensure the financial stability of their hospitals. The second tape, "The Role of Clinical and Financial Data in Hospital Management," explains the important role that merged clinical and financial data play in hospital management. Each 20-minute color videotape, which comes in either the 3/4" or 1/2" (VHS only) format, can be purchased for \$30 or rented for \$10 by sending a check to AMRA's Order Unit, P.O. Box 97349, Chicago 60611.

•Norwich Eaton Pharmaceuticals has produced a new 23-minute color film on the causes and effects of genitourinary tract infections, especially those that are nosocomial in nature. The film is available on free loan in either 16mm or Super 8 mm format. Write the Norwich Eaton Audio-Visual Library, 17 Eaton Ave., Norwich, N.Y. 13815.

# Vaccine-Related Injuries

Compensation for vaccine-related injuries has been advocated by the American College of Physicians.

The major problem of mass immunization programs, says the ACP, "is the occurrence of an infrequent but statistically inevitable number of vaccine-related injuries that will afflict a small number of recipients, due to no fault or negligence of any party."

The college believes it appropriate that those who benefit from immunization programs—individuals, society, and vaccine manufacturers—should share the costs of compensating these victims for expenses incurred while acting for the good of society.

# New Sleep Disorders Drug

Stuart Pharmaceuticals has received "orphan drug status" on Vivalan, a new drug for sleep disorders. The FDA confers "orphan drug status" on those drug discoveries that treat diseases afflicting small numbers of people and consequently do not have great commercial value.

Vivalan will be appropriate for a small number of patients with narcolepsy and cataplexy. The total number of patients in the U.S. is estimated at 42,000 for narcolepsy and 60,000 for cataplexy but only a portion of these patients will require the new drug. The "orphan drug" classification provides various allowances and a "fast-track" approval system.

# Inaugural Microsurgery Meeting

The American Society for Reconstructive Microsurgery will hold its inaugural meeting Jan. 18 and 19, at The MGM Grand Hotel in Las Vegas. The initial meeting of the newly organized society will include a short business session. The bulk of the time will be spent on scientific talks and discussions on thumb reconstruction, osseous tissue transfer and facial reanimation. Full information may be obtained by phoning (212) 920-5551.

# Film on 'Chest Pains'

To help increase public awareness of the symptoms and possible serious significance of chest pains, the American College of Physicians (ACP) has released "Chest Pains," a film that features real patients and doctors of internal medicine working to resolve actual cardiac and noncardiac medical problems. "Chest Pains" is available free to civic organizations, industry, cable television, and other groups.

Although heart attack may be the leading cause of death in America, not all chest pains indicate heart trouble. Hiatal hernias, ulcers, and muscle or skeletal strain or injury also may cause chest pains. Regardless of the cause, however, symptoms of chest pain require prompt attention by an appropriate physician.

A 25-minute documentary, "Chest Pains" is the second film in the ACP's HEALTHSCOPE<sup>TM</sup> education program for the American public. "Chest Pains" describes both the potential benefits and limitations of modern medical care in a thoughtful, honest way. The film presents the latest knowledge and recommended methods of treatment, as well as current diagnostic tests and procedures. Filmed in LaGrange, Ga., "Chest Pains" focuses on internist Robert B. Copeland, M.D., and his patients.

The HEALTHSCOPE series is produced under an educational grant from The Upjohn Company of Kalamazoo, Mich.; additional films will show the serious significance of other worrisome symptoms such as headaches, abdominal discomfort, excessive thirst, and common ailments. "Aches, Pains and Arthritis," the first HEALTHSCOPE film, was released in April 1984 and is available from the ACP, 4200 Pine St., Philadelphia 19104.

# Cochlear Implant

Dr. Peter M. Zonakis, an otolaryngologist who practices in Valparaiso, reports to Indiana Medicine the first cochlear implant operation performed in Indiana outside Indianapolis. Dr. Zonakis is a coinvestigator with the House Ear Institute and the FDA concerning this operation.

#### **New ISMA Members**

The following physicians were welcomed in September as new members of the Indiana State Medical Association:

Fernando G. Aguila, M.D., Anderson, anesthesiology.

Panos C. Alexander, M.D., Kokomo, general surgery.

Russell K. Ameter, M.D., Fort Wayne, family practice.

Lawrence R. Bailey Jr., M.D., Aurora, family practice.

Michael L. Baldwin, M.D., Richmond, emergency medicine.

James W. Banks III, M.D., Indianapolis, family practice.

James W. Beeson, M.D., Anderson, emergency medicine.

Michael R. Brown, M.D., Terre Haute, radiology.

Ramon R. Contreras, M.D., Terre Haute, obstetrics and gynecology.

J. Valentine Corcoran, M.D., Indianapolis, internal medicine.

Charles H. Dickerson, M.D., East Chicago, head and neck surgery.

David R. Emery, M.D., Lafayette, pulmonary diseases.

Galen Epp, M.D., Goshen, internal medicine.

Jack Farr II, M.D., Indianapolis, orthopedic surgery.

Leon Flemembaum, M.D., Fort Wayne, family practice.

William J. Granger IV, M.D., Lawrenceburg, anesthesiology.

Thomas R. Green, M.D., Indianapolis, anesthesiology.

Jack A. Harris, M.D., Marion, ophthalmology.

Don M. Henry, M.D., Munster, obstetrics and gynecology.

David E. Hyde, M.D., Marion, family practice.

Mark A. Jensen, M.D., Warsaw, general surgery.



Andrew R. Jones, M.D., Bloomington, orthopedic surgery.

Bruce A. Lockwitz, M.D., Elkhart, rheumatology.

Rodney W. Mail, M.D., Indianapolis, anesthesiology.

John R. Malooley, M.D., Greenwood, neurology.

Debra K. McDaniel, M.D. Spencer, pediatrics.

Duane L. Miller, M.D., Elkhart, emergency medicine.

Scott A. Miller, M.D., Fort Wayne, ophthalmology.

Samuel A. Montanya, M.D., Fort Wayne, obstetrics and gynecology.

Joseph L. Novak, M.D., Fort Wayne, occupational medicine.

Victorio K. O'Yek, M.D., Merrillville, thoracic surgery.

Henry F. Olivier Jr., M.D., South Bend, cardiovascular surgery.

Soja Park-Bennett, M.D., Fort Wayne, endocrinology.

Russell W. Pellar, M.D., Munster, general surgery.

Christopher W. Penoyar, D.O., Fort Wayne, family practice.

Robert W. Petry, M.D., Columbus, allergy.

Dana S. Pfaff, M.D., Lafayette, urological surgery.

Michael J. Phend, M.D., Elkhart, internal medicine.

Susan G. Phillips, M.D., Indianapolis, otorhinolaryngology.

Mridula R. Prasad, M.D., Merrillville, neurology.

Michael E. Pratt, M.D., Indianapolis, emergency medicine.

Jeffrey B. Quillen, M.D., Richmond, emergency medicine.

Gary T. Raflo, M.D., Indianapolis, ophthalmology.

Jay L. Schlabach, M.D., Goshen, family practice.

Dale A. Sloan, M.D., Fort Wayne, general surgery.

R. Porter Smith, M.D., Bluffton, ophthalmology.

Marc Thomas, M.D., Fort Wayne, diagnostic radiology.

David E. Van Ryn, M.D., Mishawaka, emergency medicine.

Samuel L. West, M.D., Michigan City, family practice.

John E. Westfall, M.D., Fort Wayne, otorhinolaryngology.

David R. Wippermann, M.D., Franklin, general surgery.

#### - Physician Recognition Awards -



The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Neely, Michael L., Danville Park, Jung I., Munster Pickerill, James M., Lafayette Rahmany, Mohammad A., Highland Serrano, Jose F., Munster



Shriner, Philip O., Fort Wayne Sugarman, Donald R., Fort Wayne Winters, Peter L., Indianapolis Wolf, Robert A., Munster Wu, L.Y. Frank, Indianapolis Ziperman, Don B., Indianapolis

Cavins, John A., Indianapolis Gerlanc, Milan D., Evansville Lauer, Dean H., Valparaiso

December 1984

Adams, Robert H., Kokomo

Basavaraja, Hiremat, Muncie

Brill, Joseph B., Jeffersonville

INDIANA MEDICINE

#### NEWS NOTES\_

#### Here and There

**Dr. Susan Siebenmorgen Amos** of Terre Haute has been named a diplomate of the American Board of Family Practice.

**Dr. Steven P. Grossnickle**, a Warsaw ophthalmologist, has been elected to the board of directors, First National Bank of Warsaw.

**Dr. Richard F. Graffis** of Indianapolis has been elected president of the Indiana Division, American Cancer Society; **Dr. Joe G. Conley** of New Albany was elected vice-president.

**Dr. Ronald D. Nelson** of South Bend, **Dr. Lawrence D. Rink** of Bloomington, and **Dr. Trent G. Orfanos** of Merrillville have been elected to fellowship in the American College of Cardiology.

**Dr. Philip Leder**, chairman of the genetics department, Harvard Medical School, has received the first **Steven Beering Award** for the advancement of medical science; Dr. Beering, president of Purdue University, was dean of the I.U. School of Medicine from 1974 to 1983.

**Dr. James Moneyhun** of Anderson discussed the early practice of medicine during an October open house at the Madison County Historic Home (the Gruenewald Home).

#### CME Quiz

CONTINUED FROM PAGE 975

- c. Combination chemotherapy, including adriamycin
- d. Tamoxifen
- In the premenopausal patient with a steroid-receptor-positive tumor and subcutaneous metastasis, the treatment of choice would be:
  - a. Combination chemotherapy
  - b. Electron beam therapy to involved sites
  - c. Ovariectomy
  - d. Aminoglutethimide plus hydrocortisone
- 10. In the premenopausal patient with a steroid-receptor-negative tumor and liver metastasis, the treatment of choice would be:
  - a. Combination chemotherapy
  - b. Lobectomy if tumor confined to one lobe of the liver
  - c. Radiation therapy to the involved liver
  - d. Combined chemotherapy and hormonal therapy

**Dr. William J. Mankin**, a Terre Haute ophthalmologist, was presented the Indiana State University Alumni Association's Distinguished Alumni Award during ISU's annual homecoming celebration in October.

**Dr. David A. Frieske** of Valparaiso has been appointed chief medical officer at Porter-Starke Services, Inc., and Vale Park Psychiatric Hospital.

**Dr. J. Thomas Benson**, an associate clinical professor of Ob-Gyn at the I.U. School of Medicine, was elected to the board of directors of the Gynecology Urology Society during the society's annual national meeting.

**Dr. Frederick B. Stehman** of Indianapolis is serving as chairman of the Utilization Review Committee of the I.U. Medical Center.

**Dr. Richard S. French**, an Indianapolis neurologist, was the featured speaker at the October meeting in Indianapolis of the Parkinson Awareness Association.

**Dr. David J. Dwyer**, a Noblesville internist and geriatrics specialist, discussed "How Your Body Changes with Age" at the October meeting at Riverview Hospital of the Respiratory Health Club.

**Dr. Paul A. Boyce**, an Indianapolis diabetes specialist, was the guest speaker at Methodist Hospital's annual "Diabetic Dining Out Evening" last month.

**Dr. Shokri Radpour**, a Kokomo otorhinolaryngologist, presented two papers at the Fifth International Symposium on Facial Nerve, held in Bordeaux, France, Sept. 2-6; he also has been elected secretary-treasurer of the American Neurotology Society.

**Dr. John B. Oak** and **Dr. John F. Ansbro**, Evansville cardiologists, participated in a panel discussion on heart disease during an October community health forum at Deaconess Hospital.

**Dr. Bruce Williams**, an Evansville pediatrician, discussed diabetes programs for children and adults during an October public health program in Evansville.

**Dr. William H. Leech** is the new chief of the medical staff at Culver Union Hospital, Crawfordsville; **Dr. Thomas E. Topper** is vice-president, and **Dr. S. Reddy Marri** is secretary-treasurer.

**Dr. Michael A. Borkowski** of South Bend discussed rheumatoid arthritis in October as part of a public lecture series.

**Dr. Juan Tan** of Munster has been board certified in emergency medicine.

**Dr. Brent J. Holleran**, an Indianapolis thoracic surgeon, was the guest speaker at an October meeting in Beech Grove of the Circle City Mended Hearts Club.

**Dr. David L. Jetmore**, a Richmond otorhinolaryngologist, discussed middle ear disease during the fall meeting in Indianapolis of the Indiana Hearing Aid Specialist Association.

Dr. Walter P. Beaver of Noblesville discussed depression during an October meeting at Riverview Hospital.

**Dr. Francis W. Price**, **Jr.**, an Indianapolis ophthalmologist, addressed the October luncheon meeting of the Indiana Society to Prevent Blindness.

**Dr. Ronald C. Hamaker** and **Dr. Mark 1. Singer** of Indianapolis presented a course on voice restoration after laryngectomy at the annual meeting in September of the American Academy of Otolaryngology-Head and Neck Surgery.

**Dr. Larry D. Lovall** of Danville discussed preventive health care at a fall meeting of the Danville Rotary Club.

**Dr. Cesar S. Archangel** of Jeffersonville and **Dr. Mohsen Ehsan** of New Albany addressed a fall meeting in New Albany of the Arthritis Self-Support Group.

**Dr. David S. Batt**, an Indianapolis rheumatologist, discussed the causes and forms of arthritis during an October public forum at St. Francis Hospital, Beech Grove.

**Dr. John A. Forchetti** of East Chicago discussed mitral valve prolapse and balloon coronary angioplasty during a September program sponsored by the Michigan City Mended Hearts Club and St. Anthony Hospital.

#### **Hepatitis B Vaccine**

Biogen announces an agreement with the Wellcome Foundation providing for the marketing of Biogen's hepatitis B vaccine in world markets. The vaccine is made from proteins produced by genetically altered yeast. Since the process does not involve any contact with infected human plasma, the laborious and expensive purification and testing procedures to eliminate the potential of infection are not required.

#### Mobile CT Unit Serves Four Wisconsin Hospitals

Four competing hospitals in Wisconsin are sharing a mobile computed tomography (CT) scanner in a non-profit venture that has enabled them to provide the diagnostic service that none of them individually could afford.

Two of the hospitals are in Sheboygan, and two are in Manitowoc, 20 miles away. The two Sheboygan hospitals, with a total of 435 beds, started the project in 1982 when it became apparent that neither could "cost-justify" a fixed-based CT scanner, nor was such a request likely to pass certificate-of-need laws.

A mobile unit provided the needed alternative. By including other hospitals—the two in Manitowoc have a total of 331 beds—the cost to each hospital was reduced by sharing.

The mobile CT unit logs 160 miles a week traveling to the four hospitals. Hospital visits are confined to half a day so that the scanner can be at all four hospitals every two days. By moving the unit every half day, a patient is never more than a day and a half away from a scanner visit. In two years, more than 3,000 patients have been treated.

#### Consensus Conference

"Health Implications of Obesity" will be the subject of an NIH Consensus Development Conference scheduled for Feb. 11-13.

#### Physical Therapist Sues for Dismissal from Staff

Whether a physical therapist was subject to the bylaws of a hospital's medical staff should not have been decided on a summary judgment motion, the Alabama Supreme Court has ruled.

The physical therapist entered into a contract with the hospital in 1980. He was given the exclusive right to provide physical therapy services. The hospital billed his patients and paid him a portion of the funds collected. He submitted an application for membership on the medical staff. By return mail, the hospital advised him that the board of directors had approved his appointment to the medical staff. Enclosed with the letter was a copy of the bylaws and rules and regulations of the medical staff.

He treated patients until his contract expired on June 30, 1982. At that time the contract was awarded to another therapist. The first therapist claimed that his staff privileges continued and that he could continue to treat patients at the hospital. The hospital then sent him a letter stating that, after reviewing its bylaws, it determined that therapists were not eligible for membership on the medical staff. His initial appointment to the staff was an error and the hospital terminated his privileges.

The therapist filed suit claiming that he was entitled to a hearing under the bylaws before his privileges could be terminated. A trial court dismissed the action for failure to state a claim.

Reversing the decision, the Supreme Court said that the therapist's claim that the hospital bylaws constituted a contract with him and that it breached the contract stated a claim. There were substantial fact issues as to whether the therapist was a member of the hospital's medical staff and summary judgment was improper, the court said.—Clemons v. Fairview Medical Center, Inc., 449 So.2d 788 (Ala. Sup.Ct., April 6, 1984)

#### What the Law Says About Extending Credit

If you allow your patients to make installment payments on their bills, you are required by law to register with the Consumer Credit Division, Indiana Dept. of Financial Institutions.

The Dept. of Financial Institutions is responsible for enforcing the Indiana Uniform Consumer Credit Code (IC 24-4.5). There is no fee for registering.

You become subject to the code if, by written or oral agreement, you permit a patient to make four or more installment payments without an interest charge, or to make two or more installment payments with an interest charge.

To register, write to the Consumer Credit Division, Dept. of Financial Institutions, 1024 State Office Bldg., Indianapolis 46204. For more information, call Mel Wright or Bob Haler, Consumer Credit Division—(317) 232-3955.

#### INDIANA MEDICAL BUREAU

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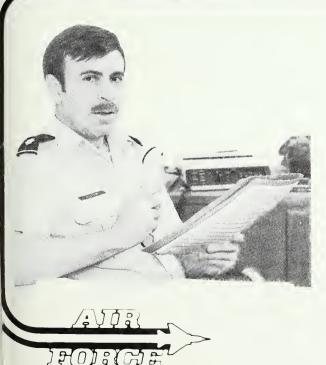
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A foundation for charitable, educational, and scientific purposes, organized by the ISMA as an endowment fund to support the educational mission of the Assocation and INDIANA MEDICINE.

Bequests, legacies, devises, transfers or gifts to the Foundation or for its use are deductible for federal estate and gift tax purposes, in accordance with the Internal Revenue Code.

The Foundation is managed by a board of directors that comprises the members of the ISMA Executive Committee. At present, proceeds from the Foundation investments are awarded to INDIANA MEDICINE to further the continuing medical education program.

Memorial contributions made to the Foundation in lieu of flowers will be acknowledged by the secretary in a letter to the family of the deceased.

> "for religious, charitable, scientific, literary or educational purposes"

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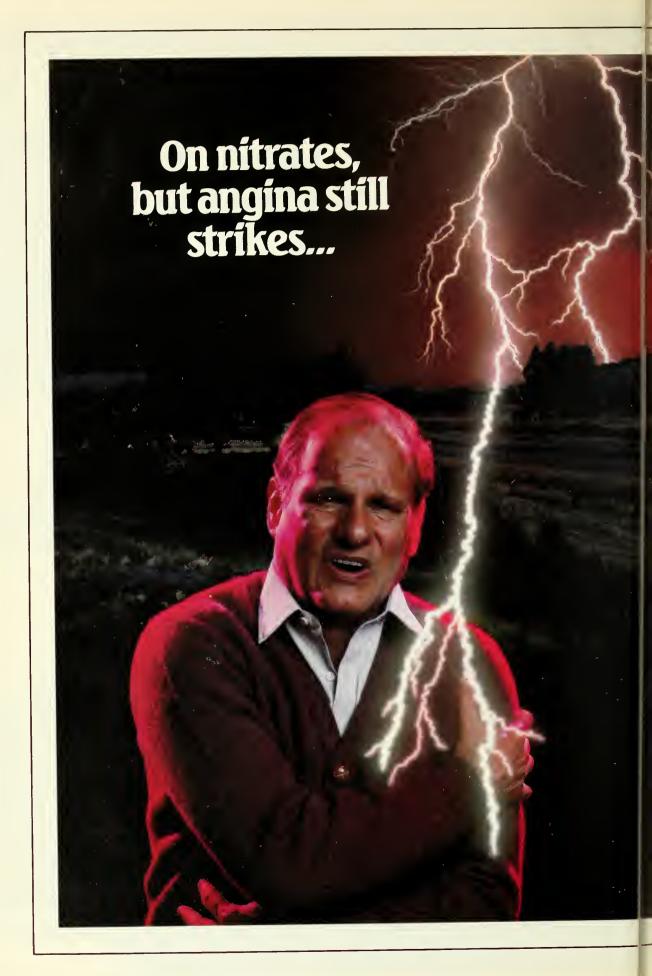
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First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the

single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of
Isoptin are similar to those
of beta blockers: severe
left ventricular dysfunction,
hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome
(if no artificial pacemaker is present)
and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

#### ISOPTIN TABLETS

(verapamil HCl/Knoll) 80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see Warnings), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rddegree AV block. Warnings: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or digretics before ISOPTIN is used ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or de-pressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored ISOPTIN may have an additive hypotensive effect in patients receiving bloodpressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia; HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. How Supplied: ISOPTIN (verapamil HCI) is supplied in 80 mg and 120 mg sugar-coated tablets July 1982

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## **TRUTH**

When the North Atlantic Treaty Organization was formed in 1949, it was formed for one reason. To stop Soviet aggression in Europe.

## TRUTH

The Warsaw Pact's conventional fighting capabilities far exceed that of European NATO forces.

## **TRUTH**

In order to maintain peace and freedom in Europe, NATO has effectively maintained a policy of deterrence with the Soviet Union.

## **TRUTH**

The past 35 years of peace have been one of the longest periods of European peace in recorded history.

## **TRUTH**

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#### 1984

### CONVENTION REPORT

PHOTOS BY JOYCE WOLF AND BOB SULLIVAN



Dr. Shirley Khalouf, House speaker, and Dr. Fred Dahling, vice-speaker, preside over the second session of the 135th annual meeting of the House of Delegates during which nearly 40 resolutions were introduced.



Dr. William J. Sabo of Munster (left) and Dr. Thomas C. Tyrrell of Hammond check the House of Delegates Handbook for the phrasing of a resolution.



Dr. Donald J. Kerner (left) and Dr. Stephen Jay of Indianapolis listen to the reading of a Reference Committee report.



Dr. Paul Siebenmorgen (at microphone) discusses his views on an issue prior to a House of Delegates vote. (Dr. Siebenmorgen was chosen president-elect during the convention).



Dr. Lukemeyer (left), outgoing president, administers the oath of office to newly elected or re-elected ISMA officers.



President-elect Lawrence E. Allen (left) presents a plaque in recognition of service to outgoing president, Dr. George T. Lukemeyer.



Members of the head table applaud visiting dignitaries during the President's Dinner.



Reference Committee hearings, held Friday night and Saturday morning, were well attended.



Dr. Willard S. Krabill of Goshen, chairman of Reference Committee 3 (legislation), indicates the next topic of discussion.



Approximately 175 Indiana physicians, spouses and guests attended this year's IMPAC luncheon.



Mr. and Mrs. Fred Kinghorn (left) were special guests during the meeting of INDIANA MEDICINE'S Editorial Board. Mr. Kingborn has been designing the magazine's front covers more than 25 years. Seated to the left of Dr. Charles A. Bonsett, author of the popular "Medical Museum Notes" column, is Ms. Katherine M. McDonell, curator of the Medical Museum and managing editor of the newsletter, "Snakeroot Extract," which appears quarterly in INDIANA MEDICINE.



Nine speciality meetings were conducted Sunday.



Mr. Michael Dunn of Michael Dunn and Associates, Washington, D.C., presents the keynote address during the IMPAC luncheon.



Rep. Andrew Jacobs Jr., chairman of the House Ways and Means Committee and the House Subcommittee on Health, discussed the financing of graduate medical education during the meeting of the Association of Indiana Directors of Medical Education (AIDME).



Newly installed members of the ISMA Fifty Year Club. (A complete listing appears on page 1061.)



Kenneth W. Bush (second from right), ISMA assistant executive director since 1976, is applauded by past presidents of ISMA after being appointed an honorary member of the Association. An official Resolution of Commendation appears in the resolutions insert. Mr. Bush has been employed by ISMA nearly 25 years.



Past Presidents luncheon. The ISMA has 18 living past presidents.



Dr. Lukemeyer (right) presents a recognition plaque to Dr. Siebenmorgen, who completed three years as chairman of the Board of Trustees.



Dr. John D. MacDougall of Beech Grove, newly elected chairman of the Board of Trustees, conducts a reorganizational meeting of the Board.



Indiana Governor Robert Orr congratulates Dr. Malcolm O. Scamahorn of Pittsboro, an AMA delegate, after awarding him the honorary title, "Sagamore of the Wabash."



Mrs. Judy Koontz of Vincennes, ISMA Auxiliary president, accepts a bouquet of flowers from Dr. Lukemeyer following her address to the House of Delegates.



Dr. Harlan H. Tyner of Indianapolis takes time out at an ISMA booth to buy tickets for the President's Dinner. At right are John Wilson and Susan Grant, ISMA staffers.



From left, Dr. Paul Siebenmorgen, Don Foy (ISMA executive director) and Dr. Lowell Steen share viewpoints.



Doctors test equipment such as a spirometer offered by Med-Rep, Inc. of Carmel.



Addressing medicine's various ethical implications of clinical judgment during a general meeting Saturday afternoon were (from left) David H. Smith, Ph.D., chairman and professor of religious studies, Indiana University; Dr. Morris Green, Lesh Professor and chairman of the Dept. of Pediatrics, I.U. School of Medicine; Dr. Nancy W. Dickey of Richmond, Tex., vice-chairman of the AMA's Judicial Council; and Dr. J. Lee Dockery, associate dean, University of Florida. Total attendance at this year's convention was 1,001.





A Dista Products Co. representative, Rou Diersing (top photo, left) discusses pharmaceuticals with Dr. R. Adrian Lanning of Noblesville, an ISMA alternate trustee. At left, doctors find the computer equipment offered by technical exhibitors especially interesting. Nearly 30 technical exhibitors participated in this year's convention.

December 1984

INDIANA MEDICINE

#### 1984 Physician Community Service Award

Dr. Ross L. Egger, a family practice specialist in Daleville, received the Indiana State Medical Association 1984 Physician Community Service Award at the ISMA annual convention in Indianapolis, Friday, Oct. 19.

Dr. Egger, who was graduated from Ball State University in 1959 and the I.U. School of Medicine in 1962, received the award from Dr. George T. Lukemeyer, ISMA president.

Sponsored each year by A. H. Robbins Pharmaceutical Company, Richmond, Va., the award recognizes outstanding service to one's community in the public interest.

Dr. Egger, who started the totally volunteer Emergency Medical Service in Middletown, Ind., initiated discussions with Muncie governmental offices which eventually led to an Emergency Medical Service/Paramedic Service for Delaware County. In addition, Dr. Egger organized the Shenandoah Athletic Club, which originated a youth football program, and later organized the Shenandoah Athletic Boosters, who have provided over \$30,000 to the athletic fund in four years.

The recipient of the "Muncie Mover" Award, Dr. Egger was a Little League



Ross L. Egger, M.D. Daleville Family Physician

football coach for five years, a Little League baseball coach/manager for four years, and organized and ran the Halloween Parade for the Chamber of Commerce. A speaker at many community lay group meetings, he is a member of the Middletown Lions Club and the Middletown Methodist Church.

Dr. Egger, recipient of the 1980 Outstanding Family Practice Teacher Award, started the first Family Practice Residency in Indiana (5th in the country) and was one of the founders of the first general practice/family practice club in the United States, which now claims more than 100 members.

A diplomate of the American Board of Family Practice, Dr. Egger is also a member and past president of the Indiana Academy of Family Physicians; member and former delegate and alternate delegate to the ISMA; member and former ISMA delegate and alternate delegate to the American Medical Association; and a charter fellow and former alternate delegate to the American Academy of Family Physicians. In addition, he has served as a member of several commissions and committees in these organizations and currently serves as a member of the ISMA Commission on Public Relations.

He and his wife Noralynn have two daughters and two sons and reside in Middletown.

#### Call to Order, Miscellaneous Business

The House of Delegates convened its 135th Annual Convention, featuring the theme "Revolution in Patient Care," at 1 p.m., EST, Friday, Oct. 19, 1984, at the Radisson Hotel, Indianapolis, Ind. The final session of the House of Delegates convened at 9:30 a.m., EST, Monday, Oct. 22, 1984. Presiding at both sessions were Dr. Shirley T. Khalouf, speaker, assisted by Dr. Fred Dahling, vice speaker. Dr. Lloyd L. Hill, Peru, served as parliamentarian. Invocation was given by Donald L. Cochran, Ph.D., Minister, Southport Christian Church.

#### **Approval of Minutes**

The proceedings of the 134th Annual Meeting of the House of Delegates, held at the Executive Inn, Evansville (October 14-17, 1983) and published in the December 1983 issue of The Journal of the Indiana State Medical Association (renamed Indiana Medicine in 1984) were approved.

#### **Election of Officers**

Dr. Lawrence E. Allen, Anderson, as president-elect, succeeded to the office of president. Dr. Paul Siebenmorgen, Terre Haute, was elected president-elect. Other elections included:

Treasurer—Dr. George Rawls, Indianapolis

Assistant Treasurer—Dr. Max Wesemann, Franklin

Speaker of the House—Dr. Shirley T. Khalouf, Marion

Vice Speaker of the House—Dr. Fred W. Dahling, New Haven

Chairman, Board of Trustees—Dr. John MacDougall, Beech Grove

Clerk/Chairman Pro Tem, Board of Trustees—Dr. Michael Mellinger, La Grange

At Large Member, Executive Committee—Dr. Mark M. Bevers, Seymour

At Large Member, Executive Committee—Dr. Davis W. Ellis, Rushville

#### Elected/Reelected Trustees, Alternates—1984-85

#### Trustees:

District 2—Dr. Ralph W. Stewart, Vincennes

District 5—Dr. Benny Ko, Terre Haute District 7—Dr. William H. Beeson, Indianapolis

District 8—Dr. William C. VanNess, Summitville

District 11—Dr. Edward Langston, Flora

#### Alternate Trustees:

District 5—Dr. Fred Haggerty, Greencastle

District 7—Dr. Donna Meade, Indianapolis

District 8—Dr. Douglas Triplett, Muncie

District 11—Dr. Jack Higgins, Kokomo

#### In Memoriam

Tribute was extended to members of the Indiana State Medical Association who died since the 1983 session.
H. Clair Amstutz, M.D., Goshen Parker R. Beamer, M.D., Oak Park, H.

(formerly of Indianapolis) Horace D. Bell, M.D., South Bend Lester D. Bibler, M.D., Indianapolis Fay F. Boys, M.D., Naples, FL

(formerly of East Chicago) Robert H. Brosius, M.D., Fort Wayne James S. Browning, M.D., Indianapolis Hargis R. Bush, M.D., Cannelton Hugo M. Cahn, M.D., Indianapolis Melville E. CaJacob, M.D., Terre Haute Alfred Chona, M.D., Munster James F. DeNaut, M.D., Knox George R. Donahue, M.D., West Lafayette C.B. Fausset, M.D., Brownsburg Walter J. Filipek, M.D., South Bend Herbert Frank, M.D., South Bend William H. Garner, M.D., New Albany Richard P. Good, M.D., Kokomo Howard B. Hamilton, M.D., Indianapolis Stanley M. Hammond, M.D., Michigan City Daniel M. Hare, M.D., Evansville

Walter G. Hunsberger, M.D., Lafayette Laverne B. Hurt, M.D., Delray Beach, FL (formerly of Indianapolis) Joseph D. Imhof, M.D., Muncie George M. Jewell, M.D., Kokomo E.F. Jones, M.D., Rensselaer William A. Karsell, M.D., Carmel Harley M. Kauffman, M.D., Evansville Charles H. Kenner, Jr., M.D., Indianapolis Frederick L. Kiechle, M.D., Evansville Emmett B. Lamb, M.D., Indianapolis Chet K. Lamber, M.D., Indianapolis Otto F. Lehmberg, M.D., Columbia City James D. Lukins, M.D., Salem William C. McConnell, M.D., Sunman Corley B. McFarland, M.D., South Bend K. Randolph Manning, M.D., Indianapolis William J. Miller, M.D., Fort Wayne Francis B. Mountain, M.D., Port St. Lucie, FL (formerly of Connersville) Roy V. Myers, M.D., West Palm Beach, FL (formerly of Indianapolis) Leonard W. Neal, M.D.. Munster Louis T. Need, M.D., Indianapolis Leonard L. Nesbit, M.D., Anderson H. Eugene Newby, M.D., Sheridan Lowell W. Painter, M.D., Winchester Chris A. Pascuzzi, M.D., South Bend Robert W. Phares, M.D., Kokomo

Thomas J. Quilty, M.D., New Paris Forrest F. Radcliff, M.D., Evansville Ruth F. Rasmussen, M.D., South Bend Elsie Reid, Indianapolis Antone C. Remich, M.D., Munster Edgar E. Richards, M.D., Russellville John L. Rittmeyer, M.D., Muncie H. Harold Rodin, M.D., South Bend Sam I. Rotman, M.D., Jasonville John W. Rousseau, M.D., Angola Andrew E. Russo, M.D., Crown Point William J. Ryan, M.D., Columbus Henry R. Schroeder, M.D, Evansville Vernon A. Shanklin, M.D., Vincennes Tom G. Sheller, M.D. Logansport Duncan M. Shields, M.D., Chesterton Herbert L. Shroyer, M.D., Dunkirk David B. Silbert, M.D., Shelbyville Edward B. Smith, M.D., Inverness, FI (formerly of Indianapolis) Lloyd H. Smith, M.D., North Manchester Sydney L. Stevens, M.D., Indianapolis Jefferson I. Streepey, M.D., New Albany Thomas F. Teller, M.D., Evansville Herbert Ulkes, D.O., North Judson Lester W. Veach, M.D., Bainbridge Edwin D. Williams, M.D., Gary John F. Wixted, M.D., Harbert, MI (formerly of Mishawaka) Bruce A. Work, M.D., Frankfort

Eli B. Harter, M.D., Lafayette

(formerly of Fort Wayne)

Richard R. Horswell, M.D., Lafayette

John L. Humphreys, M.D., Bethel Park, PA

Francis W. Porro, M.D., Evansville

#### Call to Order, Miscellaneous Business

#### Election of Delegates, Alternate Delegates to the AMA

The following were elected to two-year terms as delegates and alternate delegates to the American Medical Association, their terms to expire Dec. 31, 1986:

#### Delegates:

Dr. Everett E. Bickers, Floyds Knobs Dr. Malcolm O. Scamahorn, Pittsboro Dr. Gilbert M. Wilhelmus, Evansville

#### Alternates:

Dr. Alvin J. Haley, Carmel Dr. John A. Knote, Lafayette

Dr. Robert M. Seibel, Nashville

#### Holdover Delegates and Alternate Delegates: (Terms expire Dec. 31, 1985) Delegates

Dr. Marvin E. Priddy, Fort Wayne

Dr. Peter R. Petrich, Attica

Dr. Thomas C. Tyrrell, Hammond

#### Alternates:

Dr. Martin J. O'Neill, Valparaiso Dr. Arvine G. Popplewell, Indianapolis

Dr. Vincent J. Santare, Munster

#### Scientific Exhibit Awards

3rd Place Award: "The Effect of Alcohol on the Skeletal System"

Exhibitor: Dr. Raymond O. Pierce, Jr. 2nd Place Award: "Direct Determination of Muscle Strength, Speed and Endurance"

Exhibitor: Dr. Larry K. Steinrauf

1st Place Award: "The Peculiar Features and Mysterious Nature of Duchenne's Muscular Dystrophy"

Exhibitor: Dr. Charles A. Bonsett

Members of Judging Committee: Dr. Joe C. Christian, Dr. Shokri Radpour and Dr. Franklin A. Bryan, chairman.

#### Dr. Siebenmorgen Chosen President-Elect

Dr. Paul Siebenmorgen of Terre Haute was chosen president-elect of the Indiana State Medical Association Oct. 22 during the 135th annual convention in Indianapolis.

Dr. Siebenmorgen, a specialist in family practice, was elected by the 200-member House of Delegates during the final session of the House. He will assume the presidency of the ISMA at its 136th annual convention in South Bend in October 1985.

Dr. Lawrence E. Allen, an Anderson urologist, succeeded Dr. George T. Lukemeyer of Indianapolis as president.

Dr. Siebenmorgen, who served as chairman of the ISMA Board of Trustees from October 1981 to October 1984, received a B.S. degree in Education from Indiana State University in 1941 and the M.D. degree from the I.U. School of Medicine in 1944. After completing his internship at Methodist Hospital in Indianapolis, he served in the U.S. Army Medical Corps from 1945 to 1947.

A native of Terre Haute, Dr. Siebenmorgen maintained a solo private practice there from 1947 until July 1984 when his daughter, Dr. Susan Siebenmorgen Amos, joined him in the practice of fami-



ly medicine. Dr. Siebenmorgen, a charter fellow of the American Academy of Family Physicians since 1972, has been an associate, clinical faculty, Terre Haute Center for Medical Education, since 1974; preceptor, Department of Family Medicine, Indiana University School of Medicine, since 1968; and was an instruc-

tor, St. Anthony Hospital School of Nursing, from 1948 to 1958.

He has been a member of the Vigo County Medical Society, ISMA and American Medical Association since 1947. In addition, he has been a member of the Terre Haute Academy of Medicine since 1947; American Academy of Family Physicians and Indiana Academy of Family Physicians since 1956.

Dr. Siebenmorgen has held offices in a large number of medical organizations including: ISMA trustee, 10th Medical District, 1978-1984; president, Vigo County Medical Society, 1970-1971; president, Terre Haute Academy of Medicine, 1974-1975; president, Indiana Academy of Family Physicians, 1980; Terre Haute Regional Hospital staff president, 1976, and trustee, 1977 to 1981; president, Terre Haute Medical Education Foundation, 1978; chairman, Citizen's Advisory Committee, Terre Haute Center for Medical Education, 1980-1982; and is presently serving as cochairman, Long Range Planning Committee, Indiana Academy of Family Physicians.

He and his wife Jane have three children and reside in Terre Haute.



## ISMA Welcomes Its 142nd President

Lawrence E. Allen, M.D.

President Indiana State Medical Association 1984-1985

Dr. Lawrence E. Allen of Anderson accepted the presidency of the Indiana State Medical Association Oct. 22, during the final session of the House of Delegates at the 135th annual convention of the ISMA.

Dr. Allen, a former speaker of the ISMA House of Delegates, succeeded Dr. George T. Lukemeyer, Indianapolis, as president of the Association.

Dr. Allen, a urologist, received his medical degree from the I.U. School of Medicine in 1963 and an A.B. degree from Hanover College in 1959. Originally from Bloomington, he completed five years of internship and residency programs at Methodist Hospital in In-

dianapolis before moving to Anderson.

A fellow of the American College of Surgeons and a diplomate of the American Board of Urology, Dr. Allen has served as an instructor for the I.U. Medical Center senior elective course program and as a local and state board member for the American Cancer Society.

He has held offices in a large number of medical organizations including: delegate, ISMA; vice-speaker, ISMA House of Delegates; member, Executive Committee, ISMA; chief of surgery, Community Hospital, Anderson; president, St. John's Hickey Memorial Hospital medical staff; vice-chairman, Madison County Comprehensive Health Planning Council; and chairman, Medical Advisory Committee to Congressman Dan Burton.

Dr. Allen is a member of the Madison County Medical Society, ISMA, American Medical Association, Indiana Urological Society, American Urological Association, American College of Surgeons, American Association of Clinical Urologists, American Geriatric Society, American Fertility Society, North Central Section of AUA, Pan-Pacific Surgical Association, and Societe Internationale D'Urologie, United States.

He and his wife Lucreta have three children and reside in Anderson.



#### ISMA TRUSTEE DISTRICTS

#### **Reference Committees**

REFERENCE COMMITTEE NO. 1:		REFERENCE COMMITTEE NO. 4:	
Reports of Officers		Med. Ed. and Ins.	
Robert D. Dodd, M.D., South Bend*		A. Alan Fischer, M.D., Indianapolis*	
(St. Joseph County—District 13)	FP	(Marion County—District 7)	FP
Paul T. Maier, M.D., Lafayette		Mary E. Carroll, M.D., Crown Point	
(Tippecanoe County—District 9)	CD	(Lake County—District 10)	FP
Frederick H. Buehl, M.D., Vincennes		Ray H. Burnikel, M.D., Evansville	
(Knox County—District 2)	P	(Vanderburgh County—District 1)	CRS
Ordonio J. Reyes, M.D., Rushville		Wymond B. Wilson, M.D., Mentone	
(Rush County—District 6)	GS	(Kosciusko County—District 13)	FP
David J. Need, M.D., Indianapolis		Stephen D. Tharp, M.D., Frankfort	
(Marion County—District 7)	PD	(Clinton County—District 9)	IM
		William K. Schmied, M.D., Jeffersonville	
		(Clark County—District 3)	U
REFERENCE COMMITTEE NO. 2:		REFERENCE COMMITTEE NO. 5:	
Constitution and Bylaws		Miscellaneous	
William L. Strecker, M.D., Terre Haute*		William E. Weber, Jr., M.D., Bloomington*	
(Vigo County—District 5)	AN	(Owen-Monroe County—District 2)	PS
James E. Swonder, M.D., Richmond		Richard Pitman, M.D., Columbus	
(Fort Wayne-Allen County—District 12)	GE	(Bartholomew County—District 4)	DR
William J. Sabo, M.D., Munster		Thomas A. Neathamer, M.D., Jeffersonville	
(Lake County—District 10)	ORS	(Clark County—District 3)	FP
Laurence K. Musselman, M.D., Marion		Harry D. Tunnell, M.D., Fort Wayne	
(Grant County—District 11)	Р	(Allen County—District 12)	GS
John C. Lowe, M.D., Indianapolis		Freeman Martin, M.D., Indianapolis	
(Marion County—District 7)	GE	(Marion County—District 7)	FP
		Dean Beckman, M.S., Indianapolis	
		(Student Council, I.U. Medical School)	
REFERENCE COMMITTEE NO. 3:		REFERENCE COMMITTEE NO. 6:	
Legislative		AMA Matters	
Willard S. Krabill, M.D., Goshen*		Marvin E. Priddy, M.D., Fort Wayne*	
(Elkhart County—District 7)	PH	(Allen County—District 12)	FP
James M. Rausch, M.D., Fort Wayne		Daniel T. Ramker, M.D., Hammond	
(Allen County—District 12)	R	(Lake County—District 10)	GS
Walter R. Vaughn, M.D., Vincennes		Michael O. Monar, M.D., Rockport	
(Knox County—District 2)	U	(Spencer County—District 1)	FP
Barbara J. Bourland, M.D., West Lafayette		Fred C. Poehler, M.D., LaFontaine	
(Tippecanoe County—District 9)	PDC	(Wabash County—District 11)	AN
Donald J. Kerner, M.D., Indianapolis	ran-	Ivan T. Lindgren, M.D., Aurora	V V
(Marion County—District 7)	FP	(Dearborn County—District 4)	FP
Larry G. Cole, M.D., Yorktown	r.p.	Mark Hochstetler, M.D., Indianapolis	ED
(Delaware County—District 8)	FP	(Marion County—District 7)	FP

<sup>\*</sup>Chairman

#### CREDENTIALS COMMITTEE:

Richard Schaphorst, M.D., Chairman Ray Burnikel, M.D. Robert Mouser, M.D. Thomas Felger, M.D.

#### CHIEF TELLER:

Frederick Poehler, M.D.

#### House of Delegates

ADAMS (I)

Norval S. Rich, Decatur

ALLEN-FORT WAYNE (9)

Charles H. Aust, Fort Wayne Fred W. Dahling, New Haven Robert W. Dettmer, Fort Wayne Thomas A. Felger, Fort Wayne Fouad A. Halaby, Fort Wayne Marvin E. Priddy, Fort Wayne Mitchell B. Stucky, Fort Wayne Edwin E. Stumpf, New Haven Harry D. Tunnel, Fort Wayne

**BARTHOLOMEW-BROWN (3)** 

Richard Pitman, Columbus Edward L. Probst, Columbus Robert M. Siebel, Nashville

BENTON (I)

\*\*\*Manley K. Scheurich, Oxford

BOONE (I)

Paul R. Honan, Lebanon

CARROLL (1)

T. Neal Petry, Delphi

Richard L. Glendening, Logansport

CLARK (2)

Olegario J. Ignacio, Jeffersonville William K. Schmeid, Jeffersonville

CLAY (1)

Paul E. Houston, Brazil

CLINTON (1)

Stephen D. Tharp, Frankfort

DAVIESS-MARTIN (2)

Horace Norton, Washington

**DEARBORN-OHIO (2)** 

\*\*Gerald Bowen, Lawrenceburg

\*Gordon Fessler, Rising Sun

DECATUR (1)

\*\*\*Robert Acher, Greensburg

DE KALB (1)

Gary Lee Sheeler, Auburn

DELAWARE-BLACKFORD (4)

Larry Cole, Yorktown

\*\*Ross L. Egger, Daleville

\*\*\*Donald W. Hunsberger, Montpelier L. Marshall Roch, Muncie

DU BOIS (1)

Bernard P. Kemker, Jasper

ELKHART (3)

G. Beach Gattman, Elkhart Willard S. Krabill, Goshen John B. Guttman, Wakarusa

FAYETTE-FRANKLIN (2)

William F. Kerrigan, Connersville \*Perry F. Seal, Brookville

FLOYD (1)

Everett Bickers, Floyds Knobs

FOUNTAIN-WARREN (2)

Jack Furr, Hillsboro Atee Salvo, Williamsport

FULTON (1)

Joseph D. Richardson, Rochester

GIBSON (1)

William R. Wells, Princeton

GRANT (2)

P. J. Fisher, Marion Shirley Khalouf, Marion

GREENE (1)

\*\*\*Frederick Ridge, Linton

HAMILTON (I)

R. Adrian Lanning, Noblesville

HANCOCK (1)

\*Ray A. Haas, Greenfield

HARRISON-CRAWFORD (2)

\*Bruce E. Burton, Corydon

HENDRICKS (1)

Ted Ochsner, Danville

HENRY (1)

Craig Boone, New Castle

HOWARD (2)

Jack W. Higgins, Kokomo Tom Scherschel, Kokomo

**HUNTINGTON (1)** 

\*\*Richard Wagner, Huntington JACKSON (1) \*George Weir, Brownstown

JASPER (1)

\*Kenneth J. Ahler, Rensselaer

James S. Fitzpatrick, Portland

JEFFERSON-SWITZERLAND (2)

George L. Alcorn, Madison

JENNINGS (1)

\*\*\*Louis Calli, Sr., North Vernon

JOHNSON (1)

Max M. Wesemann, Franklin

KNOX (1)

James A. Dennis

KOSCIUSKO (1)

Wymond B. Wilson, Mentone

LA GRANGE (1)

John A. Egli, Topeka

LAKE (13)

J. Albert Carey, Gary

Mary E. Carroll, Crown Point

P. G. Iatridis, Gary

Walfred A. Nelson, Gary

Barron M. F. Palmer, Hammond

Nicholas L. Polite, Hammond

Daniel T. Ramker, Hammond

Creighton M. Rawlings, Munster

Ronald R. Reed, Hammond

William Sabo, Munster

Joseph J. Sala, Merrillville

Lee Trachtenberg, Munster

Thomas C. Tyrrell, Hammond

LA PORTE (2)

\*Barbara Backer, LaPorte

\*Richard J. Houck, Michigan City

LAWRENCE (1)

Wallace D. Johnson, Bedford

MADISON (2)

E. Drew Carrel, Anderson

William C. VanNess, II,

Alexandria

MARION-INDIANAPOLIS (29)

William H. Beeson

Garry L. Bolinger

James E. Carter

Helen G. Czenkusch

Fred R. Dallas

A. Alan Fischer

Kenneth Gray

Ray L. Henderson

Stephen J. Jav

Donald J. Kerner

John C. Lowe

George T. Lukemeyer

Loren M. Martin

B. T. Maxam

Donna J. Meade

l. E. Michael

Robert W. Mouser

Paul Muller

David J. Need

\*John G. Pantzer

William D. Ragan

George Rawls

Donald L. Rogers Robert L. Rudesill

Roland Rust

Richard B. Schnute

Willis Stogsdill

<sup>\*</sup> Missed first session

<sup>\*\*</sup> Missed second session \*\*\* Missed both sessions.

#### **House of Delegates**

Hugh K. Thatcher, Jr. Douglas H. White

MARSHALL (1)

\*\*\*Michael F. Deery, Culver

MIAMI (1)

James E. Duncan, LaFontaine

MONTGOMERY (1)

\*\*\*Thomas E. Topper, Crawfordsville

MORGAN (1)

\*\*\*Ray D. Miller, Martinsville

NEWTON (1)

M. F. Guzman, Morocco

NOBLE (1)

\*\*\*James D. Chandler, Avilla

ORANGE (1)

\*\*\*Phillip T. Hodgin, Orleans

**OWEN-MONROE** (4)

\*\*\*William Cutshall, Bloomington B. Diane Wells, Spencer William E. Weber, Jr., Bloomington Paul J. Wenzler, Bloomington

PARK-VERMILLION (2)

\*\*\*J. F. Swaim, Rockville

PERRY (1)

Robert A. Ward, Tell City

PIKE (1)

\*\*\*Donald L. Hall, Petersburg

PORTER (2)

Frank M. Sturdevant, Valparaiso John L. Swarner, Jr., Valparaiso

POSEY (1)

\*\*\*John Vogel, Mt. Vernon

PULASKI (1)

\*\*\*W. R. Thompson, Winamac

PUTNAM (1)

\*\*J. Thoma Vierig, Coatesville

RANDOLPH (1)

Donald W. Tharp, Winchester

RIPLEY (1)

\*\*\*A. A. Daftary, Batesville

RUSH (1)

\*Ordonio J. Reyes, Rushville

ST. JOSEPH (6)

Don Chamberlain, Mishawaka Kenneth Cline, Wyatt Alfred Cox, South Bend Robert D. Dodd, South Bend Richard A. Schaphorst, Mishawaka Lee Smith, Mishawaka

SCOTT (1)

\*\*\*Marvin L. McClain, Scottsburg

SHELBY (1)

Wilson L. Dalton, Shelbyville

SPENCER (1)

\*\*\*Michael O. Monar, Rockport

STARKE (1)

\*Walter Fritz, Knox

STEUBEN (1)

Kenneth A. Bison, Angola

SULLIVAN (1)

\*\*\*Glen McClure, Sullivan

TIPPECANOE (4)

Thomas A. Bridge, Lafayette Dennis Richmond, Lafayette Paul T. Maier, Lafayette

\*Barbara J. Bourland, Lafayette

TIPTON (1)

\*\*\*Terrence J. Ihnat, Elwood

VANDERBURGH (8)

\*\*\*John Bizal, Evansville

\*Bryant Bloss, Evansville Ray H. Burnikel, Evansville Charles W. Hackmeister, Evansville

\*Eugene L. Hendershot, Evansville

\*\*\*Bruce Romick, Evansville Stanton Shultz, Evansville L. Ray Stewart, Evansville

**VIGO** (3)

James T. Deppe, Terre Haute Robert R. Taube, Terre Haute William L. Strecker, Terre Haute

WABASH (1)

Fred Poehler, LaFontaine

WARRICK (1)

\*\*\*L. B. Asuncion, Boonville

**WASHINGTON** (1)

\*\*\*Mark E. Manship, Salem

WAYNE-UNION (3)

James R. Daggy, Richmond James R. Lewis, Richmond Gerald L. Price, Liberty

WELLS (1)

Harold D. Caylor, Bluffton

WHITE (1)

\*\*\* James C. Balvich, Monticello

WHITLEY (1)

\*\*\*Thomas G. Hamilton, Columbia City

RESIDENT DELEGATE

Steven G. Lester, Indianapolis

STUDENT DELEGATE

Gordon Hughes, Indianapolis

## The 1984 Convention House of Delegates Actions

Resolutions acted upon by the 1984 House of Delegates appear verbatim in the green insert of this issue. Following is an overview of those actions:

- •Dues Increase. That effective January 1985, ISMA dues be increased to \$235 per year (84-14).
- •Indiana Malpractice Act. That the ISMA continue efforts to preserve the integrity of the Malpractice Act and the Patient's Compensation Fund (84-31).
- •Impaired Physician Network. That the ISMA notify county medical societies of the availability of help for impaired physicians through the Commission on Physician Impairment, that the ISMA identify a contact person to implement referrals, and that the ISMA encourage development of impaired physician committees at county or district levels (84-33A).
- •Voting—Hospital Boards. That the ISMA develop legislation to require at least one local physician with voting privileges on the board of trustees of every tax-supported hospital (84-1).
- •Environmental Health Programs. That the ISMA support the continuance of environmental health programs (by the State Board of Health), encourage a strong medical and scientific role in these endeavors, and support legislative efforts to provide resources (through funding and policy development) that will allow the State Board of Health to more adequately control environmental pollution (84-30).

- •ISMA Conventions. That, beginning in 1986, ISMA conventions be held in the Indianapolis area unless the Board of Trustees recommends otherwise (84-11); and that, beginning in 1986, annual conventions be conducted Thursday through Sunday (84-19).
- •Generic Drug Substitutions. That the ISMA initiate programs to better inform physicians and the public about the therapeutic differences between brand name drugs and generic substitutions (84-23).
- •Public Health Services. That the ISMA support legislation for state funding of local health jurisdiction and approve the principle of state funding for all basic public health services (84-29).
- •Medicare Regulations. That the ISMA support the AMA's lawsuit challenging the constitutionality of provisions of the Medicare amendments that were passed with the Deficit Reduction Act of 1984 (84-32).
- •Medical Staff Section. That the ISMA establish an Indiana Hospital Medical Staff Section (84-17).
- •Resident Medical Society. That the ISMA Resident Medical Society have a member with voting privileges represented on the ISMA Board of Trustees (84-8); that the RMS be represented in the House of Delegates by one delegate for every 50 RMS members (84-9); and that one RMS member may be appointed at large to each ISMA commission (84-15).

#### 1984

#### RESOLUTIONS AT A GLANCE

Res. 84-1

Subject: Physician Members of Hospital Boards of Trustees

ACTION: Adopted as amended.

Res. 84-2

Subject: Committee Structure

ACTION: Adopted.

Res. 84-3

Subject: Redefinition of Functions of the Executive Committee

ACTION: Adopted and referred.

Res. 84-4

Subject: Duties and Responsibilities of Reduce Drunk Driving Committee

ACTION: Adopted as amended.

Res. 84-5

Subject: Duties and Responsibilities of Commission on Sports Medicine

ACTION: Adopted.

Res. 84-6

Subject: Article III--ISMA Constitution--Component Societies

ACTION: Adopted.

Res. 84-7

Subject: ISMA Bylaws Section 12.03--Intern and Resident Medical Society (IRMS)

ACTION: Adopted as amended.

Res. 84-8

Subject: Resident Medical Society Representatives on the ISMA Board of Trustees

ACTION: Adopted as amended.

Res. 84-9

Subject: Resident Medical Society Representation in the ISMA House of Delegates

ACTION: Adopted.

Res. 84-10 WITHDRAWN

Res. 84-11

Subject: Future ISMA Convention Locations

ACTION: Adopted as amended.

Res. 84-12

Subject: Payment for Health Care Services

ACTION: Adopted as amended.

Res. 84-13

Subject: Uniform Dues Reimbursement Policy

ACTION: Adopted as amended.

Res. 84-14

Subject: Dues Increase

ACTION: Adopted.

Res. 84-15

Subject: Resident Medical Society Representation on ISMA Commissions

ACTION: Adopted as amended.

Res. 84-16

Subject: Increasing Supply of Physicians

ACTION: Not adopted.

Res. 84-17

Subject: Medical Staff Section ACTION: Adopted as amended.

Res. 84-18

Subject: Medical Practice Law Revision

ACTION: Adopted as amended.

Res. 84-19

Subject: Meeting Days of ISMA Annual Convention

ACTION: Adopted as amended.

Res. 84-20

Subject: Chairman of the Executive Committee

ACTION: Not adopted.

Res. 84-21 WITHDRAWN

Res. 84-22

Subject: Review of Regulations

ACTION: Referred to Commission on Legislation.

Res. 84-23

Subject: Clarifying Generic Substitutions

ACTION: Adopted as amended.

Res. 84-24

Subject: Closing of Staffs and Services ACTION: Referred to the Board of Trustees.

Res. 84-25

Subject: Suggested Name Change from Impaired Physicians Committee to

Distressed Physicians Committee

ACTION: Not adopted.

Res. 84-26

Subject: Consumer Protection Division, Office of Attorney General

ACTION: Referred to Commission on Legislation.

Res. 84-27

Subject: Free-Standing Emergency Centers ACTION: Referred to the Board of Trustees

Res. 84-28

Subject: Uniform Dues Reimbursement Policy to Counties

ACTION: Not adopted.

Res. 84-29

Subject: Funding of Basic Public Health Services

ACTION: Adopted.

Res. 84-30

Subject: Reorganization of Indiana Environmental Health

ACTION: Adopted as amended.

Res. 84-31

Subject: Indiana Malpractice Act

ACTION: Adopted as amended.

Res. 84-32

Subject: Medicare Regulations ACTION: Adopted as amended.

Res. 84-33A

Subject: Indiana Impaired Physician Network

ACTION: Adopted substitute Res. 84-33A

Res. 84-34

Subject: Payment of Insurance Claims Within 15 Days

ACTION: Adopted.

PRESIDENTIAL RESOLUTION

Subject: George T. Lukemeyer, M.D.

ACTION: Adopted.

PRESIDENTIAL RESOLUTION

Subject: George T. Lukemeyer, M.D.

ACTION: Adopted.

RESOLUTION CONCERNING HUGH K. THATCHER, JR., M.D.

ACTION: Adopted.

RESOLUTION CONCERNING ISMA STAFF AND OTHERS

ACTION: Adopted.

RESOLUTION CONCERNING HONORARY MEMBERSHIP FOR KENNETH W. BUSH

ACTION: Adopted.

MEMORIAL RESOLUTION CONCERNING LEONARD W. NEAL, M.D.

ACTION: Adopted.

RESOLUTION 84-1

Introduced by: Miami County Medical Society

Subject: Physician Members of Hospital Boards of Trustees

Referred to: Reference Committee No. 3

ACTION: Adopted as amended.

Whereas, The laws of Indiana permit, however, do not require physician members on hospital Boards of Trustees; and

Whereas, Local communities have long established traditions of appointing nonphysician dedicated civic and business leaders to such boards; and

Whereas, Such members often lack prior knowledge and experience regarding the needs of the local hospital or in the field of health care; and

Whereas, Local physicians obviously possess the most authoritative knowledge and experience regarding the needs of the local hospital; and

Whereas, Economic and competitive factors mandate prudent management of hospitals today more than ever; therefore be it

Resolved, That the ISMA develop legislation to require the voting membership of at least one local physician on any tax-supported hospital board of trustees; and be it further

Resolved, That the ISMA support the standard of the Joint Commission on Accreditation of Hospitals which recommends physician membership on all hospital boards; and be it further

Resolved, That such physician should be one recommended by the medical staff.

RESOLUTION 84-2

Introduced by: ISMA Commission on Constitution and Bylaws

Subject: Committee Structure

Referred to: Reference Committee No. 2

ACTION: Adopted.

Whereas, Expertise and interest from knowledgeable physicians enhances the activities of a committee; and

Whereas, The present committee structure of not less than 4 and not more than 5 members is limiting; therefore be it

Resolved, That Section 7.02 of the ISMA Bylaws be amended to read: Except as otherwise stated in the Bylaws, a committee shall consist of not less than five (5) members appointed from the general membership of the Association and shall be appointed annually by the President. (remaining portion of 7.02 is unchanged)

RESOLUTION 84-3

Introduced by: ISMA Commission on Constitution and Bylaws

Subject: Redefinition of Functions of the Executive Committee

Referred to: Reference Committee No. 2

ACTION: Adopted; referred to Commission on Constitution and Bylaws to

make appropriate changes in section numbering and where appropriate to change terminology of Executive Committee to

Board of Trustees.

Whereas, The 1983 Supplemental Report of the Chairman of the Board included a report of the ad hoc Committee to Study the Structure/Function of the Executive Committee (as per Resolution 81-1) requested amendments to the presently stated functions of the Executive Committee; therefore be it

Resolved, That Section 5.0601 final paragraph be amended by substitution to read, The authority and functions assigned by the Board to the Executive Committee shall be reviewed annually at the first regular meeting of the Board of Trustees; and be it further

Resolved, That Section 3.0401 final sentence be amended by deletion, [shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program]; and be it further

Resolved, That Section 4.0301 fourth paragraph be amended by deletion [at such time as may be arranged by the Executive Committee]; and be it further

Resolved, That Section 4.0305 last paragraph, final sentence be amended by addition, at least annually; and be it further

Resolved, That Section 4.0305 final sentence, last paragraph (as amended) becomes 6.0202 and all other sections and subsections be renumbered accordingly; and be it further

Resolved, That Section 6.01 be amended by addition to end of first sentence, from its voting members; and be it further

Resolved, That Section 6.01 be amended by deletion of all following the 3rd sentence; (final sentence - Its Secretary shall be the Executive Director of the Association.); and be it further

Resolved, That a new Section 6.02 be added and all following sections and subsections be renumbered accordingly (Quorums becomes 6.0201), 6.02 DUTIES: It shall meet with the Executive Director on the call of the Chairman, or of any three (3) members to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Director's office and such other duties as the Board may specify during the intervals between the meetings of the Board, and shall report its actions to the Board; and be it further

Resolved, That Section 6.05 be amended by addition, following the first 3 words, and with approval of the Board; and be it further

Resolved, That Section 7.1003 be amended by substitution, (5th sentence) The actions of this committee shall be certified to the Board of Trustees. (6th sentence) Each year a report of the Committee's activities, including a financial accounting report of the fund itself as administered by the trustee, shall be made a part of the Board Chairman's annual report to the House of Delegates: and be it further

Resolved, That Section 7.1008 be amended by substitution (next to last sentence first paragraph), The arrangements and the character of any and all technical exhibits must meet with the approval of the Board of Trustees of the Association. (last sentence, first paragraph) It shall, with the approval of the Board of Trustees prepare a program for scientific work for the Annual Convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the offices of the various sections, and it shall with the approval of the Board of Trustees, arrange for scientific exhibits as a part of the Annual Convention; and be it further

Resolved, That Section 14.00 and its subsections be amended by substitution. Board of Trustees be substituted for Executive Committee throughout entire Section 14.00 and its subsections.

RESOLUTION 84-4

Introduced by: ISMA Commission on Constitution and Bylaws

Duties and Responsibilities of Reduce Drunk Driving Committee Subject:

Referred to: Reference Committee No. 2

ACTION: Adopted as amended.

Whereas, The 1983 House of Delegates mandated a new Reduce Drunk Driving Committee: and

Whereas, The duties and responsibilities of said committee are hereby submitted to this 1984 House of Delegates for its approval; therefore be it

Resolved. That Section 7.1006 be added to the ISMA Bylaws, to read: The purpose of the Reduce Drunk Driving Committee is to reduce deaths and injuries to Indiana citizens due to drunk driving to the lowest possible level. The unprecedented nature of this important commitment to the public requires that the Committee's activities be broad in scope.

RESOLUTION 84-5

Subject:

Referred to:

ACTION.

Duties and Responsibilities of Commission on Sports Medicine
Reference Committee No. 2

ACTION: Adopted.

Whereas, The 1983 House of Delegates mandated a new Commission on Sports Medicine; and

Whereas, The duties and responsibilities of said commission are hereby submitted to this 1984 House of Delegates for its approval; therefore be it

Resolved, That Section 7.1014 be added to the ISMA Bylaws, to read: The Commission on Sports Medicine shall provide liaison between the ISMA and various athletic organizations. The Commission will research issues and make recommendations in a variety of areas relating to sports medicine in our state, in an attempt to improve the medical care of Indiana athletes and related personnel.

RESOLUTION 84-6

Introduced by: ISMA Commission on Constitution and Bylaws

Subject: Article III--ISMA Constitution--Component Societies

Referred to: Reference Committee No. 2

ACTION: Adopted.

Resolved, That Article III--Component Societies, be amended to read: Component societies are those county, district or other medical societies as specified in the bylaws contained within the state of Indiana, and who hold charters from this Association.

RESOLUTION 84-7

Introduced by: Resident Medical Society

Subject: ISMA Bylaws Section 12.03--Intern and Resident Medical

Society (IRMS)

Referred to: Reference Committee No. 2

ACTION: Adopted as amended.

Whereas, The position of medical intern no longer exists in Indiana; and

Whereas, The term Intern is used throughout Section 12.03 and its subsections; therefore be it

Resolved, That the word Intern(s) be deleted throughout the Bylaws; and be it

Resolved, That the name of this organization shall be the Resident Medical Society of the Indiana State Medical Association (RMS).

RESOLUTION 84-8

Introduced by: Resident Medical Society

Subject: Resident Medical Society Representatives

on the ISMA Board of Trustees

Referred to: Reference Committee No. 2

ACTION: Adopted as amended.

Whereas, The Resident Medical Society is a newly organized and chartered component society of the Indiana State Medical Association; and

Whereas, The members of the Resident Medical Society practice in and train in different areas throughout the state of Indiana and therefore do not fall in the category of any one district; and

Whereas, Resident physicians have concerns different from those of other practicing physicians; and

Whereas, More effective communication and interaction are desired between resident physicians and the leadership of the Indiana State Medical Association; therefore be it.

Resolved, That the Resident Medical Society should have one non-voting member represent that Society on the Indiana State Medical Association Board of Trustees.

Fiscal Note: \$500-\$600

\$1,000 if alternate is also seated

(Recommended by ISMA Executive Committee)

RESOLUTION 84-9

Introduced by: Resident Medical Society

Resident Medical Society Representation Subject:

in the ISMA House of Delegates

Referred to: Reference Committee No. 2

ACTION: Adopted.

Whereas, The Resident Medical Society has been established as a component society of the Indiana State Medical Association; and

Whereas, Members of the Resident Medical Society are dues-paying members of the Indiana State Medical Association; and

Whereas, Members of the Resident Medical Society are presently physicians-intraining and present and/or potential members of county medical societies; and

Whereas, County medical societies presently are allotted one delegate to the ISMA House of Delegates per fifty members and fraction thereof; and

Whereas, The Resident Medical Society presently is allotted only one delegate and one alternate delegate to the ISMA House of Delegates, regardless of the number of members; therefore be it

Resolved, That the representation of the Resident Medical Society in the ISMA House of Delegates be one delegate per fifty members and any fraction thereof, in a manner consistent with the present system used for county medical societies.

RESOLUTION 84-10

Withdrawn by: Ramon Dunkin, M.D., President, Indiana Society of Internal

Medicine

Michael A. Hogan, M.D., Chairman, Indiana Chapter, American

Academy of Pediatrics

Charles W. Hachmeister, M.D., President, Indiana Academy of

Family Physicians

Subject:

Cognitive Services Reimbursement

RESOLUTION 84-11

Introduced by: ISMA Executive Committee

Subject:

Future ISMA Convention Locations

Referred to:

Reference Committee No. 5

ACTION:

Adopted as amended.

Whereas, The Board of Trustees of ISMA on October 20, 1980 took action, "That for future planning the annual meeting be held every other year in Indianapolis, and if possible, rotating the meeting on a north and south basis in alternate years; and

Whereas, This recommendation has been followed with a successful meeting in Evansville in 1983; and

Whereas, Future meetings are planned for South Bend in 1985, French Lick in 1987, and Merrillville in 1989; and

Whereas, The one distinctive drawback of meetings in noncentralized locations is the necessity for many physicians to travel greater distances to attend the annual convention; and

Whereas, Lack of close and immediate access to ISMA records in the headquarters office from time to time obstructs immediate background information requests of reference committees and the House of Delegates as they deliberate; and

Whereas, Transporting staff to distant convention sites adds more to the total cost of the convention; therefore be it

Resolved, That following the annual convention in South Bend in 1985, all future annual Conventions of ISMA be held in Indianapolis and Marion County or in other areas adjacent to or in close proximity to the Indianapolis area, unless an alternative site is recommended by the Board of Trustees to the House of Delegates.

RESOLUTION 84-12

Introduced by: ISMA Section on Directors of Medical Education

Subject: Payment for Health Care Services

Referred to: Reference Committee No. 4

ACTION: Adopted as amended.

Whereas, A special feature of the American system for the payment of health care services has been its inclusion of certain costs of health professions education and health research in the payment for health services; and

Whereas, The public needs well trained committed health professionals; and

Whereas, Research provides the basis for improving the quality of health care; and

Whereas, Withdrawal of financial support could have undesirable consequences;

Whereas, Withdrawal of financial support could also alter the makeup of individuals entering the health professions, therefore be it

Resolved, That payment systems should continue to help support graduate education of physicians.

RESOLUTION 84-13

Introduced by: ISMA Executive Committee

Subject: Uniform Dues Reimbursement Policy

Referred to: Reference Committee No. 5

ACTION: Adopted as amended.

Whereas, Resolution 67-6 instructed ISMA to establish a system of computerized billing for the collection of all dues and for distribution of those dues separately to the respective societies; and

Whereas, ISMA has received requests from both county and district societies for special disbursement procedures; and

Whereas, Special disbursement procedures present both an administrative drain and a financial drain for ISMA; therefore be it

Resolved, That ISMA establish a uniform dues disbursement policy that provides for ISMA distributing county and district dues on a monthly basis and that those checks be mailed within ten days of the close of each month's business; and be it further

Resolved, That the ISMA work with those counties that have special billing needs and that, when feasible, these needs be accommodated by the ISMA computerized billing system.

RESOLUTION 84-14

Introduced by: ISMA Executive Committee

Subject: <u>Dues Increase</u>
Referred to: Reference Committee No. 5 ACTION: Adopted. (Roll Call Vote)

Whereas. The breadth and depth of ISMA activities and programs continue to escalate in proportion to the increasing necessary involvement of organized medicine in legislation, public relations, member communications and governmental affairs, all designed to defend the individual physician's freedom to practice quality care; and

Whereas, The economy has experienced a cumulative rate of inflation of 76% since 1975, the last year of a dues increase for ISMA members; and

Whereas, The fiscal 1983-84 budget contains a forecast of a \$35,000 deficit; and

Whereas, The budget projection for fiscal 1984-85 will be substantially greater; and

Whereas, The special \$25 dues increase, authorized for a two year period by the 1982 House of Delegates "to pursue all avenues, including litigation if necessary regarding our opposition to health insurance programs requiring participation agreements and to establish a fund for promotion of medical philosophy and principles" becomes void at the end of fiscal 1984; and

Whereas, The percent of ISMA income derived from dues is 54% with the balance coming from investments and other non-dues sources; therefore be it

Resolved, That effective January 1985 ISMA dues be increased \$54.00 to two hundred thirty-five dollars (\$235) per year to establish a solid monetary base for ISMA's continued growth and effective impact on anticipated and unanticipated changes in the medical care delivery system.

RESOLUTION 84-15

Introduced by: Resident Medical Society of the Indiana State Medical

Association

Subject: Resident Medical Society Representation on ISMA Commissions

Referred to: Reference Committee No. 2

ACTION: Adopted as amended.

Whereas, Physicians-in-training and young physicians-in-practice represent a growing proportion of the physicians in organized medicine; and

Whereas, The Resident Medical Society has been established as a component society of the Indiana State Medical Association to represent physicians-intraining; and

Whereas, The Resident Medical Society is not a part of any region represented by an ISMA trustee medical district; and

Whereas, Each medical district is allotted at least one member on each commission of the Indiana State Medical Association: and

Whereas, Physicians-in-training are not represented on ISMA commissions: and

Whereas, Resident physicians have concerns different from those of other practicing physicians; therefore be it

Resolved, That the ISMA President may appoint one resident physician as an additional at large member to each ISMA commission.

Fiscal Note: \$1,000

Recommended by ISMA Executive Committee

RESOLUTION 84-16

Introduced by: 12th District Medical Society Increasing Supply of Physicians Subject: Reference Committee No. 3

Referred to: ACTION: Not adopted.

Whereas, The number of graduating physicians has increased to the point of meeting the physician/population needs; and

Whereas, Physician over population creates a condition leading to under utilization of talents; and

Whereas, It does not appear that a solution to this problem has been sought vigorously at an official licensure level; therefore be it

Resolved, That the Medical Licensing Board of Indiana be requested to actively seek an appropriate solution to this potential problem and communicate these actions back to the Indiana State Medical Association.

RESOLUTION 84-17

Introduced by: George T. Lukemeyer, M.D., President, ISMA

Subject: Medical Staff Section Referred to: Reference Committee No. 2

ACTION: Adopted as amended.

Whereas, Recent changes in the delivery of health care and its reimbursement have increased the complexity of medical staff functions and responsibilities; and

Whereas, The American Medical Association has formed a Medical Staff Section to respond to these changes in the medical care environment; therefore be it

Resolved, That the Indiana State Medical Association form an Indiana Hospital Medical Staff Section in accordance with the bylaws; and be it further

Resolved, That the Indiana State Medical Association encourage all hospitals in the state to send an elected representative to both state and national meetings of said section.

Fiscal Note: \$15,000

#### RESOLUTION 84-18

Introduced by: ISMA Board of Trustees

Medical Practice Law Revision Subject: Referred to: Reference Committee No. 3
ACTION: Adopted as amended.

ACTION: Adopted as amended.

Whereas, The Indiana Medical Practice Law does not require any graduate medical education in an accredited program in the U.S. prior to taking the Indiana FLEX examination; and

Whereas, All graduates of LCME and AOA accredited schools and non LCME and non AOA accredited schools may take the Indiana FLEX examination if proof of graduation is considered valid; and

Whereas, graduates of non LCME and non AOA accredited schools exceed the number of graduates of LCME and AOA accredited schools taking the Indiana FLEX examination and have a poorer pass record; and

Whereas, If graduates of non LCME and non AOA accredited schools pass the Indiana FLEX examination they are granted a provisional license to practice in Indiana for a period not to exceed two years and must serve under the "preceptorship" of a county medical society or a hospital medical staff; and

Whereas, the terms "preceptor" and "preceptorship" as expressed in the medical practice law do not convey the intent of the law regarding supervision rather than education causing confusion in the interpretation and implementation of that provision of the law; and

Whereas, the new FLEX I and FLEX II examination requirements of the Federation of State Licensing Boards are to be implemented in June 1985; therefore be it

Resolved, That that portion of the Indiana Medical Practice Law which specifies that foreign medical graduates (graduates of foreign medical schools) who have not completed two years of post-graduate training prior to passing the Indiana FLEX examination must agree to practice under the preceptorship of a county medical society or a hospital medical staff be deleted; and be it further

Resolved, That all reference to foreign medical graduates be deleted and replaced by the term "graduates of non LCME or non AOA accredited schools"; and be it further

Resolved, That to be eligible to take the FLEX I examination, all candidates must have evidence of the completion of all the educational requirements to

receive their M.D. or D.O. degree from a LCME or AOA accredited school or equivalent degree from a non-LCME or non-AOA accredited school; and be it further

Resolved, The FLEX I must be passed by the candidate prior to the completion of PGY I in an accredited program, and be it further

Resolved, That to be eligible to take FLEX II, the candidate must have successfully passed FLEX I and successfully completed PGY I In an accredited program; or as an alternative at the Medical Licensing Board's discretion, the candidate may take FLEX I and II at the same time, but in any event may not receive an unlimited license to practice medicine in Indiana until the candidate completes PGY I in an accredited program, and be it further

Resolved, That the Indiana Medical Licensing Board be fully advised of the aforementioned plans and recommendations.

LCME = Liaison Committee on Medical Education

AOA = American Osteopathic Association

FLEX = Federation Licensing Exam

PGY = Post Graduate Year

#### RESOLUTION 84-19

Introduced by: Carroll County Medical Society

Subject: Meeting Days of ISMA Annual Convention

Referred to: Reference Committee No. 5

ACTION: Adopted as amended.

Whereas, At present the ISMA annual meeting is scheduled for Friday through Monday; and

Whereas, Monday is the busiest day in many practices; therefore be it

Resolved, That starting in 1986 the annual meeting of ISMA be changed to a Thursday through Sunday format.

#### RESOLUTION 84-20

Introduced by: Fountain-Warren County Medical Society
Subject: Chairman of the Executive Committee

Referred to: Reference Committee No. 2

ACTION: Not adopted.

Whereas, In corporate organizational structure usually the Chairman of the Board of Trustees serves as Chairman of the Executive Committee; and

Whereas, In this organization the Executive Committee regularly reports and is accountable to the Board of Trustees; and

Whereas, The Chairman of the Board should be most able to direct the Executive Committee and to report any actions taken to the Board; therefore be it

Resolved, That the Chairman of the Board also serve as Chairman of the Executive Committee.

RESOLUTION 84-21

Withdrawn by: Fountain-Warren County Medical Society

Subject: Annual Meeting Site

RESOLUTION 84-22

Introduced by: Marion County Medical Society

Subject: Review of Regulations
Referred to: Reference Committee No. 3

ACTION: Referred to Commission on Legislation

Whereas, The Indiana State Medical Association is charged with the study of and response to legislative and regulatory proposals as to their effect upon the practice of medicine and the protection of the public health; and

Whereas, The Indiana State Medical Association is charged with keeping "the profession informed at all times concerning its area of responsibility;" and

Whereas, Substantial regulations affecting the delivery of medical and health service have been and are being promulgated under statutory authority by a variety of agencies without being brought to the attention of component societies and members; therefore be it

Resolved, That an appropriate body within the Indiana State Medical Association conduct a thorough evaluation of health-related agencies promulgated and proposed (1983 to present) regulations with regard to their impact on the protection of the public health and consistency with the statutory authorities under which these regulations have been or may be proposed; and be it further

Resolved, That progress reports on these efforts be made on a monthly basis to component societies.

Fiscal Note: \$5,000

RESOLUTION 84-23

Introduced by: Marion County Medical Society
Subject: Clarifying Generic Substitutions

Referred to: Reference Committee No. 4

ACTION: Adopted as amended.

Whereas, The Indiana State Medical Association supported generic substitution legislation to assist the citizens of Indiana in obtaining lower cost pharmaceutical products when medically appropriate; and

Whereas, Clinical effectiveness of generic drugs due to differences in bioavailability of their contents is recognized by physicians, despite the drugs being chemically equivalent; and

Whereas. The best clinical results for patients may be obtained through the physicians' consideration of these differences in generic drugs; and

Whereas, The interest of the public is not served by advertising and other presentations which diminish the differences among generic drugs; therefore be it

Resolved. That the Indiana State Medical Association encourage programs to better inform physicians and the public regarding the substantial differences which may have adverse consequences on the therapeutic affect of generic drugs.

### RESOLUTION 84-24

Introduced by: Marion County Medical Society Closing of Staffs and Services
Reference Committee No. 5 Subject: Referred to:

Referred to the Board of Trustees. ACTION:

Whereas, The freedom of choice available to patients can be detrimentally affected by the limitations of alternatives available to physicians rendering services in a hospital situation; therefore be it

Resolved. That the Indiana State Medical Association oppose efforts by any hospital which serves to limit physicians' free choice and competitive alternatives through the closing of Medical Staffs, Sections of Medical Staffs, or which limit physician access to services based on arbitrary objectives which do not clearly enhance patient care.

#### RESOLUTION 84-25

Introduced by: Howard County Medical Society

Suggested Name Change from Impaired Physicians Subject:

Committee to Distressed Physicians Committee

Reference Committee No. 2 Referred to:

ACTION: Not adopted.

Whereas, The name of Impaired Physicians Committee implies a determination of impairment before an actual evaluation has been accomplished; and

Whereas, The intent of the committee, either county or state, is to deal with distressed physicians before impairment has occurred; and

Whereas, Early intervention is more conducive to assistance or remediation; therefore be it

Resolved, That the name of the local, county and state Impaired Physician Committees be changed to Distressed Physician Committee.

RESOLUTION 84-26

Introduced by: Fort Wayne Medical Society

Subject: Consumer Protection Division, Office of Attorney General

Referred to: Reference Committee No. 3

ACTION: Referred to Commission on Legislation.

Whereas, The Indiana Law (Indiana Code Section 25-1-7-5) requires that complaints coming to the Consumer Protection Division of the Office of Attorney General, State of Indiana, and concerning licensees of the Medical Licensing Board, State of Indiana, must be forwarded to the Medical Licensing Board for resolution of the complaint through negotiation; and

Whereas, These complaints have and will continue to be forwarded to the Medical Licensing Board after negotiation, resolution and/or decision by panel or trial on the complaint has already taken place; and

Whereas, These complaints to the Medical Licensing Board take valuable time away from other important duties that are required of the Medical Licensing Board; therefore be it

Resolved, That the Indiana State Medical Association take appropriate action to change and/or modify the Indiana Code to exempt physicians from the jurisdiction of the Consumer Protection Division, Office of Attorney General in those instances where the complaint against the physician has been resolved previously.

#### RESOLUTION 84-27

Introduced by: Clark County Medical Society
Subject: Free-Standing Emergency Centers

Referred to: Reference Committee No. 3

ACTION: Referred to the Board of Trustees.

Whereas, Officials of several hospital associations and other independent medical groups have expressed intent to purchase, build, or subsidize "free-standing" emergency centers; and

Whereas, Presently there are no state regulations provided by the Indiana State Board of Health to govern and monitor their operation; and

Whereas, Use of the words "emergency" or "urgent" in the names of such centers may cause patients with true life-threatening emergencies to be present there inappropriately and with tragic consequences; and

Whereas, free-standing emergency centers generally do not provide for continuity of patient care which may further fragment the delivery of medical services and lessen the quality of care for the patient; therefore be it

Resolved, That the Indiana State Medical Association Commission on Legislation review the matter of the regulation of both hospital and medical group-sponsored free-standing emergency centers and draft legislation for introduction into the

Indiana General Assembly which would broadly define and regulate the utilization of similar terms and words associated with "emergency centers".

RESOLUTION 84-28

Introduced by: Vanderburgh County Medical Society

Subject: Uniform Dues Reimbursement Policy to Counties

Reference Committee No. 5 Referred to:

ACTION: Not adopted.

Whereas, Resolution 67-6 instructed ISMA to establish a system of computerized billing for the collection of all dues and for distribution of those dues separately to the respective societies; and

Whereas, Vanderburgh County Medical Society has complied with that system to date: and

Whereas, ISMA reimburses county dues to county medical societies by different arrangements resulting in inequities in the amount of interest earned by county medical societies; and

Whereas, Vanderburgh County Medical Society would like the ability to bill for special dues categories and to acknowledge receipt of dues in a timely manner; therefore be it

Resolved, That ISMA establish a uniform dues reimbursement policy that provides for ISMA reimbursing county and district dues to each respective society within thirty (30) days of receipt, revise the billing form to permit special county dues categories, and send an acknowledgment of receipt of dues to the member on behalf of Vanderburgh County Medical Society and ISMA.

RESOLUTION 84-29

Introduced by: Section on Preventive Medicine & Public Health

Subject: Funding of Basic Public He Referred to: Reference Committee No. 3 Funding of Basic Public Health Services

ACTION: Adopted.

Whereas, There is an increasing need and demand for public health services, many of these services are mandated by federal and state legislation, and are implemented by local health departments; and

Whereas, There has been a long standing problem of adequate funding for county health departments, depriving many citizens of essential basic health services; and

Whereas, The Indiana Association of Public Health Physicians is preparing legislation to address these financial problems; therefore be it

Resolved, That the ISMA support legislation for state funding of local health jurisdiction and approve the principle of state funding for all basic public health services; and be it further

Resolved, That this House of Delegates direct the ISMA Commission on Legislation to support said legislation.

RESOLUTION 84-30

Introduced by: Indiana Academy of Family Physicians

Subject: Reorganization of Indiana Environmental Health

Referred to: Reference Committee No. 3

ACTION: Adopted as amended.

Whereas, The Environmental Policy Commission appointed by Governor Orr in the Fall of 1983 will make recommendations to the Governor in late October or early November 1984; and

Whereas, The majority of testimony to date has emphasized the fact that adequate resources and policies (personnel, salaries, equipment, etc.) which are necessary to carry out a successful environmental health program have not been provided to the Indiana State Board of Health; and

Whereas, The Indiana State Board of Health has provided the <u>only</u> means for medical input, assessment and direction to the governmental control of the effects of environmental pollution on human health; and

Whereas, The Indiana State Board of Health has traditionally attempted to perform its responsibilities in a non-political, scientific and objective manner which best meets the health needs of the public; and

Whereas, The decision to totally politicize the environmental health control in Indiana is inherent in the creation of a separate Indiana agency for such purposes outside of the Indiana State Board of Health; and

Whereas, The creation of such a separate agency will require considerable, and very costly, unnecessary duplication of services and resources already present at the Indiana State Board of Health and will be terribly unsuccessful if the expense is not much greater than that needed by the current structure; and

Whereas, Such separation and politicization of environmental health will weaken and potentially could completely undermine the medical role in environmental control; therefore be it

Resolved, That the Indiana State Medical Association support the continuance of environmental health programs within their current organizational structure (the State Board of Health) and encourage a strong medical, scientific role in these endeavors; and be it further

Resolved, That the ISMA support legislative endeavors which could provide resources both through funding and policy development, to allow the current state organizational structure (the State Board of Health) to more adequately control environmental pollution for the betterment of public health.

RESOLUTION 84-31

Introduced by: 12th District Medical Society

Subject: Indiana Malpractice Act
Referred to: Reference Committee No. 4

ACTION: Adopted as amended.

Whereas, The malpractice system nationally has been identified as a significant contributor to the rising cost of health care; and

Whereas, The Indiana Malpractice Act which took effect in 1975 and established the liability of a health care provider at \$100,000/\$300,000 has created a partial solution to continuing rising health care costs; and

Whereas, The Indiana General Assembly Legislative Study Committee has proposed these limits be raised to \$200,000/\$600,000 which will result in significant premium increases to health care providers which will ultimately be paid by their patients; therefore be it

Resolved, That the Indiana State Medical Association continue vigorous efforts to preserve the integrity of the Malpractice Act and the Patients Compensation Fund.

RESOLUTION 84-32

Introduced by: Section on Medical Directors and Staff Physicians of

Nursing Facilities

Subject: Medicare Regulations
Referred to: Reference Committee No. 6

ACTION: Adopted as amended.

Whereas, The American Medical Association announced its intention in September 1984 to file a lawsuit challenging the constitutionality of provisions of the Medicare amendments that were passed with the Deficit Reduction Act; and

Whereas, The AMA believes the amendments will deny Medicare beneficiaries the ability to select the physician from whom they will receive care; and Whereas, The legislation singles out non-participating physicians alone among all segments of society by forbidding them from freely entering into contractual agreements with patients; and

Whereas, The act authorizes penalties against non-participating physicians... those physicians who do not agree to accept assignment in 100% of their Medicare cases--if they raise their charges; and

Whereas, The AMA is concerned that this legislation will severely jeopardize the availability, access and complete delivery of medical services to the American people; and

Whereas, The leadership of ISMA and AMA will begin emergency political and legal action necessary to reverse this onerous legislation; therefore be it

Resolved, That the Indiana State Medical Association wholeheartedly support this action of the American Medical Association and so advise the executive vice president of the AMA and the AMA Board of Trustees as well as the Indiana Congressional Delegation; and be it further

Resolved, That the AMA will continue to support high quality medical care for everyone and will oppose legislation that threatens to lower the quality of medical care.

RESOLUTION 84-33A

Introduced by: ISMA Commission on Physician Impairment

Subject: Indiana Impaired Physician Network

Referred to: Reference Committee No. 5

ACTION: Adopted Substitute Resolution 84-33A, as amended.

Resolved, That the ISMA notify the county medical societies of the availability of help for impaired physicians through the Commission on Physician Impairment, that ISMA identify a contact person to implement referral when necessary, and that the ISMA encourage the development of impaired physician committees on a county or district level.

RESOLUTION 84-34

Introduced by: ISMA Board of Trustees

Subject: Payment of Insurance Claims Within 15 Days

Referred to: Reference Committee No. 4

ACTION: Adopted.

Whereas, It is in the best interest of insureds, hospitals and physicians that payment for services rendered to an insurance company's beneficiary be made within 15 days; and

Whereas, Most insurance companies are capable of processing claims payments within 15 days, without significant problems; and

Whereas, many insurance companies and self-funded groups already pay claims received within 15 days; and

Whereas, Such a mandatory stimulus for insurance companies to facilitate prompt payment would more than likely assist in keeping down the rate of increase in health care costs; and

Whereas, Other states already have in place legislation requiring insurance payments to be made within 15 days; therefore be it

Resolved, That the Indiana State Medical Association propose and support legislation to require insurance companies to pay health insurance claims for services already performed within 15 days from the date of receipt.

PRESIDENTIAL RESOLUTION ACTION: Adopted.

Whereas, George T. Lukemeyer, M.D., served as president of the Indiana State Medical Association at a time when organized medicine was being challenged by the burdens of increasing governmental regulations; and

Whereas, Dr. Lukemeyer, faced with a resurgence of many of the same challenges of prior years as well as new problems threatening the quality and accessibility of medical care, represented the interests of Indiana physicians and patients with dignity, insight and wisdom; and

Whereas, At the expense of his own time and effort, family life and personal freedom, he traveled the streets and highways of Indiana to discuss with local physicians such issues as legislation regarding the elderly and indigent, changes by the insurance industry, prospective payment, cost containment, hospital medical staff standards, and numerous other matters; and

Whereas, he carried the Association's concerns for maintaining the quality and accessibility of medical care to the doorsteps of legislative study committees and legislators, the media, other state medical associations, and to allied health professional groups; and

Whereas, He encouraged physicians to be active in their communities and in the formulation of national public policies that affect the health and welfare of all citizens; and

Whereas, he has helped the Association improve its image as the patient's advocate; therefore be it

Resolved, That this House of Delegates, on behalf of the entire membership, express its gratitude and appreciation to Dr. Lukemeyer for his outstanding leadership and wish him success in his future endeavors.

PRESIDENTIAL RESOLUTION ACTION: Adopted.

Whereas, George T. Lukemeyer, M.D., has served the Indiana State Medical Association as President with esteem and dedication; and

Whereas, He has assured ISMA of his continued support and loyalty; and

Whereas, He has revered the medical profession and the field of medical education with his leadership; therefore be it

Resolved, That George T. Lukemeyer, M.D., receive our heartfelt gratitude and commendation for his devotion to the ISMA as our President.

RESOLUTION CONCERNING HUGH K. THATCHER, JR., M.D. ACTION: Adopted.

Whereas, Hugh K. Thatcher, Jr., M.D., with this Convention, marks his fiftieth year in practice and thirtieth year of service as a member of this House of Delegates; and

Whereas, As President of the Marion County Medical Society, Alternate Delegate and Delegate to ISMA, and ISMA Treasurer, Doctor Thatcher has distinguished himself as a leader and statesman; and

Whereas, Doctor Thatcher has expressed his desire to share his future October weekends with his ever-supportive wife, Mary Lou; therefore be it

Resolved, That this House of Delegates extend its heartfelt appreciation to Hugh  $\overline{K}$ . Thatcher, Jr., M.D., for his dedicated leadership and stewardship with best wishes for his future and with the understanding that he will be sorely missed.

RESOLUTION CONCERNING ISMA STAFF AND OTHERS ACTION: Adopted.

Whereas, Through the combined efforts, commitment and dedication of many groups and individuals, the 135th annual convention is drawing to a successful close; and

Whereas, The staff of the Indiana State Medical Association has worked diligently to complement the efforts of the Commission on Convention Arrangements in organizing and implementing the many activities and events of this convention; and

Whereas, The ISMA Auxiliary and the Radisson Plaza staff worked harmoniously with ISMA staff in assuring the efficient conduct of this convention; and

Whereas, The State Board of Health once again provided equipment and staff in logistical support of this convention; and

Whereas, Various contributors and technical exhibitors have assisted in the convention's education program; therefore be it

Resolved, That this House of Delegates, on behalf of the entire membership, express its gratitude for the outstanding performance of the ISMA staff and the Commission on Convention Arrangements; and be it further

Resolved, That this House also extend its appreciation to the ISMA Auxiliary, the Radisson Plaza staff, the State Board of Health, and all those who contributed to the success of this 1984 convention.

RESOLUTION CONCERNING HONORARY MEMBERSHIP FOR KENNETH W. BUSH ACTION: Adopted.

Whereas, He has served the physicians in Indiana unselfishly during his tenure with ISMA; and

Whereas, He has independently organized ISMA Annual Meetings for those year; and

Whereas, Ken could handle a "Beefeaters on the Rocks" and a good cigar beyond compare; and

Whereas, He has been both boss and friend to every ISMA staff member; therefore be it

Resolved, That Kenneth W. Bush be made an honorary member of the Indiana State Medical Association.

MEMORIAL RESOLUTION CONCERNING LEONARD W. NEAL, M.D. ACTION: Adopted.

Whereas, Leonard W. Neal, M.D., of Munster, Indiana, widely known and respected by his peers, died on May 20, 1984; and

Whereas, Doctor Neal in both his practice and his medical society activities served as an example of the true professional; and

Whereas, He served as president of the Indiana Tenth District Medical Society in 1962-63; and

Whereas, He served as president of the Lake County Medical Society in 1970-72;

Whereas, He was a long standing member of the Lake County Medical Society, the Indiana State Medical Association, the American Medical Association, and the American Academy of Family Practice; and

Whereas, He was a founder of the Hammond Clinic, a clinic that grew from the initial eight member physicians to the present membership of over fifty physicians; and

Whereas, Doctor Neal was always prepared to serve the profession and to do his part in the medical society to enhance quality medical care; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association recognize and record its appreciation for Doctor Neal's long years of dedicated service to the medical profession and the public it serves; and be it further

Resolved, That the Indiana State Medical Association convey its respect and sympathy to his widow, Mary, and to his family.

#### ACTION: Filed.

Welcome to the 135th Annual Convention of the Indiana State Medical Association. It has been an honor and a privilege to serve as President of the Indiana State Medical Association. Thank you for granting me that honor.

Please join me in recognizing and complimenting everyone who worked so hard and contributed so much to another successful year for the Indiana State Medical Association. My special thanks go to Drs. Siebenmorgen, Allen, Herb and Shirley Khalouf, Rawls, Wesemann, Bolinger, Melliner, and Dahling. Members of the Board of Trustees, the Executive Committee and the AMA Delegation also have earned our compliments. It is a pleasure to again acknowledge the superb performance of the commissions and the committees of ISMA. The work of the officers and the effectiveness of the commissions and committees is made possible through the efforts of a loyal and dedicated staff. I would be remiss if I did not tell you how much I appreciate the leadership and the support of our outstanding executive director, Don Foy. 1 wish to express my gratitude and admiration for the superlative performances of Ken, Howard, Sara, Rick, Mike, Ron, Bob, Rosanna, Beckett and the entire staff.

My quest for the presidency of the Indiana State Medical Association began in earnest in 1981. As a candidate, as president-elect and as president it has been my good fortune to attend many district meetings and other activities sponsored by the ISMA. My wife Barbara and I are grateful for the gracious hospitality which has been showered upon us. She joins with me in thanking all of you for the memories which we shall long cherish.

These three exciting years have provided me a keener appreciation for the range and variety of activities involving the Indiana State Medical Association. I know that all of you will join me in pledging whole-hearted and enthusiastic support to Dr. Allen as he assumes the responsibilities of the presidency of the Association in a time of upheavel and change.

Last year, in my president-elect ad-

dress, I pointed out my growing concern over what I perceived as a deficiency in "grass roots" involvement and participation in ISMA governance and activities. Attendance at district meetings is still disappointing. The ISMA membership has continued to increase but attendance by members at the annual meetings has been stable or declining since 1976. Only 8% of the total membership attends the annual meeting! I again anxiously await the membership attendance report for this year's annual meeting.

In recent years, the AMA House of Delegates expanded to include direct representation by specialty medical societies and established a section on hospital medical staffs with an elected delegate and alternate delegate. The Indiana State Medical Association House of Delegates includes approximately 203 voting members. I have been alarmed and disappointed by the lack of attendance at the House of Delegates meeting. Thirtythree delegates failed to attend any of the sessions of the House last year. Is one meeting a year with limited attendance adequate to insure that we have good "grass roots" involvement in the policymaking body of the State Medical Association?

Do you share my concern about this seeming lack of interest and participation in the activities of the House of Delegates? Should the size and composition of this House be reviewed? Is an annual meeting of the ISMA House of Delegates sufficient in this complex and changing society?

Your Board of Trustees and the Executive Committee assume executive and fiscal-type administrative responsibilities for ISMA throughout the year. The trustee districts vary greatly in size, both geographically and by population of ISMA members. In view of my continuing apprehension about representation and "grass roots" input, I feel compelled to again raise the question as to whether or not there should be a careful review of the Board's structure and function. I am happy to report that the Future Planning Committee has been functioning effectively throughout the year and is beginning to address these and other important

It seems appropriate for me to briefly

review some of the highlights of this past year.

The short session of the Indiana legislature began early in this year and there were a number of medically related issues which were considered.

#### S.B. 411—Health Commissioner Bill

This bill, unexpectedly introduced, makes the Commissioner of the State Board of Health a governor's appointee instead of a State Board of Health appointee. The vigorous efforts of the ISMA assured the retention of the requirement that the Commissioner of the State Board of Health must hold an unlimited license to practice medicine in Indiana. The governor signed the bill into law on March 8, 1984 and shortly after that State Health Commissioner Ronald G. Blankenbaker, M.D. resigned, effective July 1, 1984. Still under active consideration is a move, with the backing of industry, of the Environmental Policy Commission to recommend legislation for 1985 which would create a separate state agency for environmental affairs, separating health from environment. If you have strong feelings on this issue, you should make them known.

#### Generic Substitution Bill

A generic substitution law was approved during the 103rd Indiana General Assembly. This made Indiana the 50th state in the Union to adopt a generic substitution bill. This bill permits a pharmacist to dispense a lower-priced, generically equivalent drug for the prescribed drug if the patient or his legal guardian agrees to the substitution and if the prescribing physician indicates that a substitution is permissible. This bill took effect July I, 1984 and you are now using the new prescription format.

#### Medical Malpractice Law

The medical malpractice picture in Indiana is not bright. There has been a marked increase in malpractice claims filed with the Insurance Department and there have been ever-escalating claims made against the Patient's Compensation Fund. The surcharge on medical malpractice insurance premiums was increased to 50% on April I, 1984. ISMA's own actuary estimated that the deficit in the Pa-

### Address of the President

tient's Compensation Fund could soon reach \$50 to \$60 million if nothing is done to protect the integrity of the fund. ISMA's Malpractice Advisory Committee has developed recommendations which have been submitted to an interim legislative study committee. The Interim Legislative Study Committee, chaired by Representative Paul Mannweiler, will be submitting its report and recommendations to the upcoming state legislature meeting. ISMA's views will be aggressively presented.

#### Hospital Prospective Payment Commission

There is another legislative commission, chaired by Mr. Don Blinzinger. This commission has an expanded charge to determine what kind of hospital cost containment initiatives are indicated in Indiana. The commission will be reporting its recommendations this winter, and these will be of interest and significance to all physicians and hospitals. There is a dangerous drift to a state-regulated rate-setting commission for hospitals. Can state-regulated physician fee-setting commissions be far behind?

#### Medicare Assignment

Prior to the adjournment of the first session of the 98th Congress in December 1983, the United States House of Representatives was poised to act on a proposal that included a provision calling for mandated assignment in its package of Medicare and Medicaid amendments. This was not accomplished and Congress adjourned. In March 1984, the American Medical Association's Board of Trustees called upon all physicians to voluntarily freeze their fees to Medicare recipients for one year. The response to this request was and is gratifying. In the spring, Congress again considered mandated assignment as a condition of participation in the Medicare program. Hospitals would have been required to obtain an agreement from each staff physician to accept Medicare assignment (as a condition for maintaining staff privileges) for all Medicare inpatient hospital services. AMA and ISMA members notified their representatives of the dangers of the proposed amendments. The proposal was soundly defeated by a voice vote when the House Medicare and Medicaid package was considered on the

floor on April 12, 1984 as part of the House Budget Reconciliation Bill (HR 4170).

The issue of mandated assignment for Medicare claims was next considered June 12, 1984 by a joint House-Senate conference committee as part of the Deficit Reduction Act. The conferees decided not to mandate assignment, but instead adopted a 15-month fee freeze coupled with a revolutionary "participating physician" program. Physicians were required to submit their decision whether or not to be a "participating" physician by October 1, 1984. The American Medical Association, the Indiana State Medical Associaton, several Indiana physicians, and Medicare beneficiaries from Indiana filed a lawsuit against the U.S. Department of Health and Human Services challenging the constitutionality of provisions of the Deficit Reduction Act (PL 98-369) that froze physicians' fees and required physicians to decide whether or not they would accept assignment 100% of the time. AMA, and co-plaintiffs ISMA, also filed an application for a preliminary injunction to delay the October 1, 1984 deadline for physicians to decide whether to "participate" under the law. The complaint was filed in Indianapolis Federal District Court on Friday afternoon, September 28, 1984. Judge Sarah E. Barker denied the AMA-ISMA request for a preliminary injunction to stay the October 1, 1984 deadline.

#### **Public Relations Program**

The Board of Trustees approved the launching of a comprehensive, phased, multi-media communications program consisting of positive messages which position physicians as the advocates for patients. Holden and Company, a national marketing company which specializes in health-care marketing, will assist ISMA in defining the issues, selecting the audiences, selecting and preparing messages, and placing the messages in the local media. The statewide year-long communications program began in July and is projected to cost approximately \$200,000, spread over the next two fiscal years. The ISMA Executive Committee authorized \$88,000 for the first phase of the program. The program is being evaluated and a decision will be made regarding continuation and additional funding.

#### The Indiana Peer Review Organization

Responding to the resolve of the House of Delegates, ISMA assisted in forming an arms-length foundation (the Indiana Peer Review Organization). IPRO, which has approximately 1,700 physician members, was awarded a 2-year contract by the Health Care Financing Administration to do peer review for Medicare beneficiaries in Indiana. I recognize that PROs are controversial, but I am pleased that in Indiana we have a professional review organization which is physiciandirected. IPRO is sub-contracting with the Indiana Medical Review Organization in Terre Haute and the Indiana Foundation of Medical Care in Fort Wayne to do peer review in the southern third and northern third of Indiana, respectively. The IPRO will have a regional office in Indianapolis to do review in the southeastern part of Indiana. It is my fond hope that the IRPO will recognize its obligation to assure quality medical care as well as the efficient use of hospital and physician resources in providing care to Medicare beneficiaries.

# AMA House of Delegates Annual Meeting—Chicago

Dr. Malcolm Scamahorn, floor leader, directed a hard-working and an outstanding Indiana delegation at the American Medical Association's Annual House of Delegates Meeting in Chicago in June 1984. Dr. Pete Petrich was reelected to the Council on Constitution and Bylaws. The Indiana delegation was deeply disappointed when Dr. Scamahorn failed in his reelection bid for a place on the Council on Medical Services.

The ISMA Board of Trustees has recently endorsed Dr. Pete Petrich's candidacy for a seat on the American Medical Association's Board of Trustees. His candidacy has been announced and the campaign to elect Dr. Petrich will begin in earnest with the interim meeting of the AMA House of Delegates in December. All members of the delegation are enthusiastic about Pete's candidacy and we invite all of you to join us in supporting him.

### Address of the President

#### Coalitions

The Indiana State Medical Association has been active in promoting coalitions for several years. Dr. Al Haley has been especially effective in this effort. During the past year, it has been my good fortune to have served on the Indiana Chamber of Commerce's Committee on Health and to have participated in the formation of a new coalition, the Indiana Council on Health Care. It is essential that the ISMA be an active and informed participant in a variety of coalitions. We should strive to meet with organizations of retired and older Americans to explore areas of consensus in promoting available, caring and affordable medical care for older citizens.

I would like to conclude this report by discussing briefly three rather broad areas which I think should be of major importance to the Indiana State Medical Association in the coming years.

# Enhancing Membership Confidence in the ISMA

It is vital to the future of the ISMA that it enhances the confidence of its members in the organization. There is an urgent need to expand "grass roots" input and participation in policy development and implementation for the Association. The Future Planning Committee has begun a self-analysis which will review the structure and function of the Indiana State Medical Association. This review should include the organizational structure and the function of the officers, the Executive Committee, Board of Trustees, commissions and committees.

# Enhancing Public Confidence in the ISMA

The theme of this 135th annual session of the Association is "The Revolution in Patient Care." The public is deeply concerned about the escalating costs of medical care. During these tumultuous times, it is imperative that the State Medical Association renew its dedication to serving as advocate for the patients we are privileged to care for. The ISMA must be prepared, on the basis of solid data and documented information, to respond in an even-handed manner to the challenges which now confront the profession and the citizens of this great state and nation.

The Association must continue to initiate and participate in a variety of coalitions which seek to solve some of the major health and medical problems confronting our society. If we base our policy positions and actions on solid data and a true concern for patients, we can earn public confidence. It is essential that we make certain that we are careful in gathering verifiable data and that we commit our Association to responding to public policy issues in a concerned and non-self-serving way.

#### **Bioethical Issues**

It is abundantly evident that the information and knowledge explosion of the last quarter century will continue and accelerate. Technological advances will go forward at an ever increasing pace. There is a clear indication that our population will increase and that there will be strik-

ing growth in the percentage of older people. Concern over the cost of medical care has reached a fever pitch and it should be obvious to all that we are now capable of providing more medical services than society seems willing to pay for at the present time. Under these circumstances, the rationing of medical care seems inevitable. I fear that a crisis mentality will result in dollar-based criteria for making important national and state decisions about medical care. We have seen the beginning of a series of regulatory approaches which are fundamentally driven by a cost-based standard.

Physicians must continue to make decisions based upon what is good for the patient. We will not only have "Baby Doe" kinds of issues but there will be concerns about "Granny Doe." In my view, the aged, the infirmed, the underemployed, the underinsured and the indigent are at greatest risk. Physicians must participate as informed and caring members of society in the decision-making process relative to medical care. It is essential that we have a good, solid medical data base to accompany the economic concerns as we work to define policies which will dictate what resources we are willing to use in support of medical care, education and research.

Finally, this has been an instructive and exciting year for me and I thank all of you for the memories and the privilege of serving as president of the ISMA. I wish you well and pledge my full and enthusiastic support to the leadership and the membership of the Indiana State Medical Association.

# **ACTION: Referred to Board of Trustees.**

Considering many of the challenges having to do with the job of being president of ISMA, I have selected certain major topics to discuss with you today. Without doubt, one such topic is the overview of the national and state political scene for the coming 1984 elections and the year that will follow. As I assess the prevailing attitude in Washington, through visitations and conferences with our respective senators and congressmen, it is apparent that we are dealing with political leaders committed to doing something about the cost of health care even if the action they take may be wrong. Herein, I cannot help but view our congressmen with some degree of dismay as they grope with problems related to medical care in this country, and seem to do so without any uniform expression of desire for consultation with the medical community. This certainly is not unanimous and there are some very encouraging examples of physician advisory committees working hand-in-hand with the elected public official to better understand the problems confronting our medical care system, and to seek out reasonable solutions. One example I would bring to your attention is HR 6357 regarding the "covering physician" issue introduced by Congressman Burton on behalf of physicians in the 6th District. In this framework of cooperation I can only say, I applaud these congressmen, and I ask, "Why don't more public officials see this as a responsibility of their office?"

Well, what about the upcoming election in 1984 for the Presidency of this country? As we analyze the circumstances surrounding the political strength of President Reagan, we readily appreciate that he is running on a platform puncutated by certain unalterable attitudes. His basic thrust has been, and will probably continue to be, a dedicated fight against big government—big government regulation, and big government spending. So, what is the most embarrassing thing to the Reagan campaign at the present time? Any junior economist can tell you—it's the \$200-plus billion yearly deficit and the continued obligation of Big Government to Welfare entitlement financing. As far as medicine is concerned, the most confounding inconsistency in the administrative platform is the willingness to have the Federal Government regulate health care delivery.

This is clearly manifested by the type of regulatory legislation that has given us TEFRA, DRGs, and the Deficit Reduction Act of 1984. We, as physicians, hoped that with the 1980 election of President Reagan, we at last had a friend in the White House. As we have realized over the last four years, having a friend in the White House is not always the advantage that it's trumped up to be. Nevertheless, even though the present Administration may at times be exasperating, it still seems far more attractive than any of the other present-day alternatives. If we are to consider a second term for President Reagan in our future, how then must we conduct ourselves in the next four years? Certainly our efforts to communicate with the Administration, the Senate and the Congress, as everyone realizes, is only a portion of the story. And, as we survey the political inner play, we constantly see public opinion swayed by the media and special interest groups.

What role, then, does the physician play in this scenario? Well, all too often the physician has been presented as the villain-not as the compassionate dedicated person that we all feel we are, or would like to be, but rather as an opportunist who is taking advantage of the patient. We may ask ourselves, "Why has this image developed and what can we do about it?" The answer is one and the same—this inaccurate image perpetrated all too often by the criticism of the media, has been essentially unopposed by the voice of medicine. Our public has heard only one side—one voice, one criticism. Physicians have been, for the most part, silent through ineffective means of public information and communication. We have, in effect, continued to rely upon an outmoded form of pamphletering, popular in the days of Thomas Payne, but totally inadequate for today's high-tech society, where communication is accomplished by satellite and laser beam and professionally prepared and distributed. Certainly, if we are to characterize the health system in this country as an industry, that segment of it which has to do

with medical care does not compare favorably in terms of public information and distribution of information. Any other industry would annually spend 11% to 13% for such purposes. Physicians and hospitals have allocated only a token of this amount in order to tell their story to the people they serve.

What can we do to change this? Certainly the 1983 House of Delegates considered just such a question during the past year, and as you have heard President Lukemeyer describe for you, a program is under way to carry out your decision to develop a public information campaign, dealing with such issues as DRGs and other concerns having to do with the image of physicians and the overall welfare of our system of medical care in this state. We certainly will be watching with intense interest as the program initiated by the Holden Company is evaluated and re-addressed as one of the mechanisms by which we can accomplish communication with our public.

It is my personal observation that the current campaign must be further supplemented. I have, during the last few months, been in communication with some of our larger county societies, exploring the possibility of further developing the concept of the "Voice of Medicine" for radio. I encourage every local medical society to explore ways of distributing information that will help the public understand not only the viewpoint of medicine on social economic issues, but also the common sense approach to better utilization of our medical services and technology, as well as common sense measures toward life style and environmental health. There are also multiple opportunities to augment local community health care programs. In regard to the latter, I refer to public information concerning maternal and child health care, health care for the aged, health-related educational programs for schools, and sometimes just friendly advice and discussion of common medical disease entities.

This is not to say that our day-to-day communication with patients in our offices and in our various walks of life is not important—it is indeed the foundation of our strength, and the foundation of our philosophy. It embodies all that is good in medicine in our society. It is

person-to-person. It is compassion. It is helping those for whom we are responsible to help themselves by encouraging our patients to join us in accomplishing the best form of medical care available and affordable to the American public. No. my remarks concerning a step-up in our communicative ability is directed toward the appreciation that we must augment that which we do every day with communicative skills that reflect the state of the art of technology for distribution of information and essential viewpoints. It will be expensive, but it is part of the real world in which we live—a reality that we must, as curators in the field of medical service, be ready to face. We must pledge a larger portion of our financial resources to the world of communication.

Perhaps in a category of special importance is the challenge of overcoming the false barriers that separate physicians from the community of elderly patients. This is probably one of the most disturbing tragedies that I see existing for organized medicine. If there is any group in America today that needs a strong ally, it is the elderly. If there is any group that has a friend in their attending physician, it is the elderly. We must bring together the physician and his elderly patient in a working partnership.

I can pledge to you on behalf of your ISMA leadership that efforts to establish dialogue with senior citizen organizations will proceed immediately.

I am also asking this House to continue the \$25 assessment of our membership for the select purpose of sustaining an effective program of public information.

#### Marketing

My next topic of discussion has to do with the subject of marketing and why it is important to Indiana physicians and what your Indiana State Medical Association should be doing to aid physicians in developing the marketing skills necessary to practice in a competitive environment. This competitive environment is not restricted to physicians competing with physicians, but includes an ever-expanding list of competitors inclusive of hospitals and non-physician practitioners, industry, government, retailers and proprietaries.

Marketing is a social process and oc-

curs everytime a consumer purchases a product or a service. Marketing is a social process focused on creating consumer satisfaction and providing a service or a product that meets the consumer need, at an acceptable, reasonable and affordable price made available in a timely and acceptable manner. This description of marketing was contained in the remarks of Bruce Allen, vice-president of marketing strategies for the Community Hospitals of central California. Mr. Allen was one of the participants in the 1984 American Medical Association leadership conference conducted in Chicago.

It is safe to say that in view of the current competitive environment, any physician who does not display good marketing skills will find that his or her competitors will take the power of the market place away from them as well as the freedom to run their own private practice. These seem to be foreboding words, but they forecast a future reality that is becoming increasingly more imminent with each passing day. It is painfully clear that the concept of traditional medicine will radically change when for-profit firms begin to employ physicians and usurp their right to bill patients directly and determine their own fees, and thus market their skills.

Considering the rapid change in the competitive environment for the physician, the question that I find the most pertinent to your ISMA leadership is what role should the Indiana State Medical Association perform in serving the marketing needs of our members. ISMA has in the past served as a clearing house for information to its membership. This information, however, has been directed along general lines, rather than addressing the problems of individual members. This has been particularly true of the informational assessment of competitive alternatives such as the appropriateness of prepayment systems, i.e., HMOs, IPAs, and PPOs for those individuals confronted with the "contract decisions." Mr. Brent Mulgrew, associated executive director of the Ohio State Medical Association, addressed this service area for state medical associations in his commentary as a joint participant in the marketing discussion, also at the 1984 American Medical Association leadership conference. He stated that state medical associations must do more than simply verbalize about a problem, or write about it in their journals. I find myself in complete agreement with Mr. Mulgrew and suggest to you that we must commit more of our Association resources to the creation of programs that reflect and respond to the marketing needs of our membership, particularly those members represented by the Resident Medical Society.

Herein let me share with you some comments contained in a letter that I received from the Resident Medical Society president, Steven G. Lester. In his letter to me, Dr. Lester pointed out that nowhere during the education and training of medical students and residents is the importance and function of organized medicine taught; such as informational lectures on ethics, business, politics, legislation, etc. He was further concerned that a lack of knowledge existed on the part of young physicians concerning the changes and methods in health care delivery. I certainly agree that this lack of knowledge exists for many of the established practitioners as well. In view of this, the Resident Medical Society has requested that the ISMA sponsor the AMA's "Starting Your Practice" workshop for the benefit of its resident members and members beginning their practice. Dr. Lester further suggested that a monthly article be prepared for IN-DIANA MEDICINE outling alternative methods of health care delivery, as well as examples of individual practice management problems; thus presenting an educational forum through which practice management consultation could be provided to our membership on a regular basis. I concur with these suggestions and will endorse their favorable consideration by our Board of Trustees.

I would further ask this House to consider the development of a subsidiary corporation designed to provide marketing information and service for our membership. Examples of such corporations already exist under the sponsorship of the Minnesota Medical Association, the Ohio State Medical Association and the Kentucky Medical Association. The spectrum of services that can be provided by such subsidiaries is expandable, but most certainly can include such functions as

market consultation, contract review, financial planning, practice management and physician placement. The possibility of providing computer hardware and software is also a service function within the capability of such a subsidiary corporation.

# The Structure and Function of Our State Medical Association's Headquarters and Staff

I have, on numerous occasions, had discussion with your ISMA past presidents and with Mr. Foy (ISMA executive director) concerning the housing and manpower needs of our State Association. As you may know, our headquarters staff operates with a minimum of personnel, all of whom have multiple functions, which I feel they have carried out with exemplary dedication. Nonetheless, since 1975, we have followed the dictates of a balanced budget on the one hand, and a no dues increase on the other. The net result is a situation today which is insufficient to approach the programs which are already in existence, as well as the programs which we desperately need to initiate. I recognize in this dilemma the need for acquisition of additional manpower to increase the depth of our staff potential, as well as the diversification of skills. Although I ask no definitive action from this House on this matter, I do wish to solicit your support and the support of the Board of Trustees in making the necessary additions to our staff capability that will allow us to be effective in more than just sustaining the status quo.

And, now, just a few words concerning our housing needs for your State Association. As you know this is not the first time that this Association has had a close look at our residence at 3935 North Meridian. I have reviewed reports from our ISMA staff concerning the deterioration of the present structural facility, as well as the increasing shortage of space. I have listened to proposals from your Future Planning Committee, as well as the discussion of these proposals by the Executive Committee and the Board of Trustees. I feel that we must make a responsible choice to consider further housing of the Indiana State Medical Association as to location, size and function of such a facility. I ask you to direct your Board of Trustees to act upon this matter this year. Not with the intention of short stop-gap alterations in our present situation, but rather the implementation of a long-term solution, a futuristic solution. Herein, I feel that ISMA state headquarters needs visability, accessibility, and space for technology and staff that will accommodate the job that we must do in the future years.

Finally, I wish to bring to your attention my concern for inter-professional communication. This concern has been addressed in the agenda of the recent ISMA leadership conference (conducted August 24-26, 1984) and in the meeting of the ISMA Inter-Sectional Council (section chairman). Our present organizational structure depends upon county and district societies to provide a forum for discussion and dissemination of information. This is supported by our State Association staff which uses mailings, phone communication and field representation to reach our membership. The shortfall in our organizational communicative system is related to an average attendance profile of 30% or less for county society meetings and 10% for district society meetings. Hospital staff meetings by comparison are attended by 60 to 80% of the active staff membership. Our State Association is composed of 23 specialty sections, but communication between specialty sections and the ISMA leadership and Board of Trustees is infrequent. Mailings to our membership are at times sluggish and ill-suited for communicating urgent information.

Consequently, the state of the art of ISMA communicative capability is not sufficient for optimum effectiveness. In view of the importance of improving inter-professional communication, I submit the following proposals to this House for your considerations:

- 1. I recommend enlisting the consultive services of a communication expert to upgrade our systems of interprofessional communication.
- 2. And further, I recommend the formation of a hospital staff section.

#### Dissertation on Medical Malpractice— Another Crisis Issue

As the Indiana representative on the Public Relations Committee of the North

Central Section of the American Urological Association, I was recently asked by the committee to present a report and participate in a discussion of the Indiana experience with the Malpractice Law of 1975 (PLI46).

I presented an overview of the experience that Indiana has had with its malpractice law, as well as the prospective changes that we anticipate rising out of the General Assembly during the upcoming calendar year. I made special reference to our concern for the Patient Compensation Fund and its solvency. I pointed out the likelihood that an increase in the cap limit for the primary carrier would go from \$100,000 to \$200,000. There is also a provision in the recommendation by the Legislative Malpractice Study Commission for small claims such as less than \$20,000 to be directed to court settlement, thus bypassing the panel. I addressed the recommendations that ISMA and liaison members of various provider agencies, such as Indiana Hospital Association, Indiana insurance carriers, (such as Fort Wayne Medical Protective) and Insurance Commissioner Donald Miller have proposed for the future management of the Patient Compensation Fund. These suggestions primarily have to do with professional claims management, the possibility of making the award system a one-tier system, and the insurance commissioner's suggestion that the issues of liability and damages should be decided at the primary insurance carrier level. The present ISMA position is one of endorsement for the socalled single-tier system. It is felt that the simultaneous settlement of a claim with both the primary carrier and the Patient Compensation Fund would help resolve the problem that the insurance department has had with the unavailability of information and the issue of medical causation in the "closed cases" that are presented for payment from the fund. Inherent within the so-called single-tier approach would be the potential for a structured settlement of the entire award, thereby providing the injured patient with an advantaged financial situation vis-avis favorable tax treatment and the assurance of receiving adequate funds over a long term. Consequently, the rationale for granting the insurance depart-

ment the flexibility of structured settlements is to ease the financial stress upon the fund and provide long-term benefits to those injured patients and their families. It is our understanding that approximately one-third of all claims entering the fund are the result of primary awards being settled on a structured basis by the insurance carriers.

I also reviewed the status of HMO coverage in the Malpractice Statute as of 1984, wherein the HMO as an entity is currently considered as an individual health care provider. It is the recommendation of ISMA that the liability of HMOs should be similar to that of hospitals. In other words, recognizing that there is an increased frequency in the number of patient encounters, thus increasing the potential for more than three \$100,000 judgments in any one year, the limits of risk and liability should be increased to \$1,000,000 for the total year's occurrences.

#### Liability Problems of the DRG System

At the inception of the Medicare amendments resulting in the DRG program, our initial fears sprang from the realization that such a change in the distribution of health care in hospitals would predictably place physicians at an increased exposure to malpractice litigation. After having reviewed the report of Vincent Maressa, executive director for the Medical Society of New Jersey, it appears that our fears are coming true.

Physicians in New Jersey have experienced a significant increase in malpractice cases since 1980. Claims have shifted from matters of improper medication in non-surgical classes, and matters of technique failure in surgical classes, to allegations having to do with failure to diagnose, or claims of misdiagnosis. Since 1980, 30% of lost dollars paid out on surgeons and 40% of lost dollars paid out on non-surgeons were attributable to diagnostic errors. This phenomena has not, as yet, occurred anywhere else in other states.

New Jersey is a special "test case" as far as the effect of the DRG system upon the quality of medical care delivery, since physicians and patients have had the earliest and longest exposure to implementation of DRGs in New Jersey hospitals. Since the Advent of the DRG system in New Jersey, requests for laboratory studies and requests for diagnostic x-rays for hospital inpatients have declined at the same time that major allegations of misdiagnosis have accelerated. For most of us, this is no surprise, since we have conceived from the very beginning that liability problems are built into the DRG system.

Nationally, in 1982 the average malpractice settlement was just under a million dollars for court room settlements. Some observers have described the malpractice dilemma as a runaway social atrocity, with states like New York reporting annual premiums of \$58,000 for obstetrics and gynecolocy, while the frequency of litigation in states like Florida has increased to one of three doctors each year. Congress, in recognizing the enormity of the problem, has sought to accomplish a national solution in terms of no-fault legisation, known as the Alternative Medical Liability Act. The legislative design of this act is to limit the amount of malpractice claim award to those patients whose medical care is paid for by the federal government. Herein, the act further attempts to restrict malpractice awards to amounts representing actual economic loss and would exclude compensatory awards for pain and suffering.

As a personal comment, I do not see the metholodgy of "no-fault" offering us a workable solution to the malpractice compensation dilemma. Experiences with workmen's compensation have given us insights into the enormity of expense that is escalating in the workmen's compensation system. Also, it seems unlikely that the federal government can conduct such a program as no-fault compensation for those patients who rely upon federal funding for their health care, without exacting a number of rigid and intrusive regulatory measures for physicians and patients alike. It also seems unlikely when one considers the scapegoat mentality of our society at large, that any program in which physicians are found in favor, will have the opportunity for passage. This particular legislative issue of no-fault has received heated criticism from representatives of the Trial Lawyers Association who contend that the present system of

contingency, as well as the level of awards that are gained both pre-judicially, as well as through the courts, is justified by the fact that the true incidence of malpractice is some 10 to 20 times the number of litigatable cases that are filed each year. Such a statement reflects a lack of understanding on the part of spokesmen for the Trial Lawyers Association, and to some degree on the part of the public itself in regard to what constitutes the reality of human performance in any profession.

The comments by the critics of physicians are often stated as indictments, in language having heavy intonations implicating that physicians are actually ethically or morally corrupt, and this is the reason that they make the mistakes that would be classified as malpractice. I suggest to you that no real progress will be made in the best interest of the public and all concerned until the dimensions for excellence that characterize the performance of any professional are brought within realistic accord.

To hold one profession in critical acclaim because the members of that profession are unable to display a greater than human performance in terms of accuracy is, at the best, counter-productive, and has no future benefit to society. Rather, we should emphasize the standards of education and preparation of skills that are consistent with the best abilities of those professionals, and to recognize that the human profile will continue to include the unfortunate disappointments, relative to the inability to make correct decisions, and affect the desired result in all patients all the time.

In view of this reality, our emphasis must be on the means by which we can assist in the compensatory process for patients who suffer untoward results, and do so in the most affordable and economically efficient manner. This is the attitude that respresents the compassionate concern of the physician, and this is the attitude which should direct us toward a healthy relationship with our public, our economic institutions, and our representatives of the legal profession.

Having an enormously expensive methodology for bringing compensatory monies to those citizens who need economic relief for their medically related losses is a burden our society should no

longer tolerate. Large percentage contingency fees coming at the end of prolonged expensive and sometimes theatrical excesses on the part of those representatives of the plaintiff, and at times, the defense, are not in the best interest of our citizens at large, and are totally unacceptable procedures of demeanment for physicians. Such legal practice will only serve to bring about the continued escalation of costs for reasonable health care. In the modern day experience of our health care delivery system, there is even less excuse for the abusive manner in which litigation is allowed to affect the patient and doctor relationship. Physicians and compensation fund program administrators must be able to work handin-hand in bringing about the necessary economic relief for adversely affected citizens and do so in the most economically efficient method.

# ISMA Auxiliary—A Magnificent Resource

I remember vividly my first experience at the podium in October 1977, when the House of Delegates convened for the 128th Annual Convention of the ISMA in Indianapolis. I rose to introduce a lady, who gracefully walked to the front of our Assembly and addressed the House as president of the ISMA Auxillary. Her name was Mrs. John Stanley, and she spoke of membership, legislation, CPR, immunization and impaired physicians. She emphasized the importance of unity and working for the common cause of medicine, and she recognized in her remarks the need to inform patients of our common goal—that being to promote the best available health care at the lowest possible cost.

In the years that have followed I have had the privilege of hearing the annual address of a succession of extraordinarily fine Auxiliary leaders. Each time, as I applauded the work of the Auxiliary, I thought of the *magnificent resource* they represent to our State Medical Association and to the local communities wherein they provide our most important liaison with the public.

As I survey the political and social economic environment surrounding our health care system in America, and more specifically in Indiana, I anticipate a

challenge of exhausting proportions facing physicians if the health care system that "cares" is to be preserved. One fact stands without question-doctors will not win this struggle alone. Only if we gain the full support of the citizens of the state, and the institutions they sponsor, and the political representatives they elect, will we be successful. Wherein will come the resources to accomplish this task, certainly not from the 5,000 physicians who are already committed to a 58-hour per week practice schedule . . . . certainly not from the existing ISMA staff, which is sufficient only for the custodial duties necessary to continue business as usual.

A brief look at the budget constraints built on an Association attitude that a "no dues increase" track record since 1975 is good fiscal policy, confirms the fact that ISMA is also financially limited. Where then are we to look for the resources to sustain our quest to preserve for our patients the freedom of choice of medical care at reasonable cost and dependable quality? The answer has been with us for the past 40 years and is 2,500 members strong. We have seen their effectiveness in such state-wide programs as voluntary effort, school immunizations, seat belts for children and the campaign against drunk driving—to name a few. A specific example of the effectiveness of their program for immunization of school children is the decreased incidence of measles and mumps in recent years. Consider the fact that in 1962, nearly one-half million cases of measles were reported, and by last year this had dropped to I,400. A similar decline has occurred in the incidence of mumps-in 1968, 150,000 cases were reported, and by last year this figure was down to 3,000.

More recently, the AMA Auxiliary initiated a voter registration project for physicians and their families called "Medvote." This project was started when it was realized that a significant percentage of physicians and their family members were not registered. Organizing a nationwide voter registration drive has been accomplished through the dedicated work of state Medvote chairmen. The Medvote chairman for Indiana is Ann Schuster and her visability and vitality of service in this capacity is a standard of leadership deserving of our heartfelt admiration.

We are now realizing the need for an even stronger commitment from the ISMA Auxiliary—that being to meet the challenges of new legislation facing medicine. The biggest job before us today is the ever demanding vigil we must exercise over the legislative process. If the voice of medicine is to be heard on the legislative scene today, we must form a more comprehensive and aggressive liaison through "key" contracts with lawmakers and sustain that contact year after year. It is my intention to appoint such a liaison committee of Auxiliary members who have demonstrated their effectiveness in the legislative arena in past years. I would like to appoint such Auxiliary members to this Legislative Liaison Committee for terms of two and four years and consider these terms renewable. I realize that not all Auxiliary members have an interest in politics, but those Auxilians who do have such an interest, and the aptitude for political activities, represent a tremendous resource that can strengthen the political forces of organized medicine.

I would consider this liaison committee to have as its major objective, the development of a "key" contact program made up of both Auxiliary and non-Auxiliary physician spouses. It would be my hope that such non-Auxiliary members would eventually become Auxiliary members through service to the Legislative Liaison Committee. The activities of the liaison committee would include speaking engagements by invitation for the purpose of addressing individual county Auxiliary societies and explaining the legislative issues and activities involving medicine. This liaison committee would also communicate with our legislative commission and IMPAC board for the purposes of developing a common viewpoint that would express 1SMA policy on legislative matters. The liaison committee would be instrumental in initiating fund raisers and letter campaigns. The chairman of this Legislative Liaison Committee would assume a position of Auxiliary Legislative/IMPAC coordinator, appointed by the ISMA president for the service term of four years that would be renewable by decision of the ISMA president, in consultation with ISMA Auxiliary, 1SMA Commission on Legisla-

tion and the IMPAC board.

For the purposes of refinement of skills and preparation for "special issue" related legislative campaigns, it is suggested that workshops on a state or regional basis for both ISMA and Auxiliary members should be a part of our calendar year. I'm further suggesting that "data processing equipment" be utilized for the listing of ISMA and Auxiliary members by home address, voting dis-

trict, and office address; and that a continued update of this information be conducted every two years. I also propose that a system for emergency and routine contact with our ISMA and Auxiliary membership be devised and prepared for deployment. Finally, I propose that ISMA through its Association staff and membership, launch a campaign to increase Auxiliary membership to at least an equal par basis with ISMA member-

ship.

Auxiliary provides ISMA with a powerful companion. Willingness, ability, and dedication to the ideals of the medical profession, combined wth intelligence and responsible action is an apt description of our ISMA Auxiliary. The Auxiliary and ISMA working together in cooperation is a combination that will enable the family of medicine to meet the challenges of our future.

# Address of the ISMA Auxiliary President

**Judy Koontz** 

#### ACTION: Referred to Board of Trustees.

I am very happy to have been invited to speak with you this afternoon on behalf of the Auxiliary. Your Auxiliary is what it is because of your interest, guidance, and willingness to allow us to be your partners in medicine.

The Auxiliary's fiscal year began May 1; therefore, our year is in full swing. In June, state delegates and officers attended the AMA Auxiliary Annual Convention in Chicago. In August, our summer Board meeting was held in Indianapolis. In September, we sponsored an Indiana Auxiliary Leadership Conference in Indianapolis. From October 14 through 16, nine county presidents-elect, three state officers and Rosanna ller attended the AMA Auxiliary Leadership Confluence in Chicago. It was an absolutely invaluable leadership meeting for the Auxiliary, as well as for the personal growth that took place. On this Sunday, we will hold our Fall State Board meeting. Between these flurries of activity, we moms tried to get in county Auxiliary visits, laundry, grocery buying, and carpooling for the children!

Both our summer Board meeting and our Leadership Conference were held at the ISMA headquarters. I want to sincerely thank you for providing us with a meeting place. Over 60 Auxilians from all over Indiana attended the conference. We believe it was of great value for them to be able to visit your offices and to meet your staff.

Speaking of staff, I hope all of you are aware of the courteous, friendly, efficient, and hard-working people in the office who carry out your day-to-day business. Their assistance is truly appreciated, especially that of Roasnna Iler, our ISMA liaison.

This year's motto is "Make Someone Happy by Caring and Sharing." We are asking all of our members—your spouses—to join hands under our Auxiliary rainbow to work together toward common goals. It is a colorful, cheerful, and happy approach even though we are quite aware that it takes first the rain, then the sunshine, to create a rainbow. We Auxilians are tough and we can weather the storm to gain the satisfication of a job well done. We are your best source of volunteer help. Together we can make a difference.

When we talk about broad areas of Auxiliary involvement, we are talking about for categories. They are:

- 1. AMA-ERF Fund Raising
- 2. Health Projects
- 3. Legislative Issues
- 4. Membership Challenges

American Medical Association Education and Research Foundation fundraising projects are conducted all over Indiana and the nation. Medical families and their friends contribute to this foundation to help provide funds for medical schools and especially for medical student assistance. Last year almost \$2 million was raised nationally. The Indiana University School of Medicine has received the single largest donation for several years. Two medical student recipients of AMA-ERF funds, their spouses, and Dean Daly and Mrs. Daly will be Auxiliary's special guests at our Auxiliary Day Luncheon on Sunday.

This year we are continuing participation in a statewide health project: "An Early Start to Good Health." Often we work in coalition with other volunteer service organizations for cost containment and reduction of duplication of services. "An Early Start . . ." is a program developed by the American Cancer Society. They provide the materials and training for the volunteers. We Auxilians are the volunteers. We present this health awareness program in participating schools in grades kindergarten through three. We feel this is a very worthwhile project and are glad that participation is increasing.

As the Auxiliary tackles the mountain of legislative issues before them, they look to the AMA Auxiliary and the ISMA legislative staff for direction and assistance. It is our duty to be aware of and informed about issues affecting health, health care delivery, and increasing government intervention. The Auxiliary has participated in the AMA "Project Medvote" campaign. We would like to extend a hearty

## Address of the ISMA Auxiliary President

thank you to all those who have worked so diligently on this voter registration project.

At our leadership conference in September, the discussion groups and evaluation form reports indicated a strong desire by many members to develop a program called "A Day at the Capitol." It could include tours of the state capitol, a luncheon, and a special "crowd-pleasing" speaker.

Membership is the base of our Auxiliary rainbow. It is the foundation of our organization. A top priority for this year is to increase membership. One approach has been to issue a membership challenge from Indiana to the state Auxiliary of Michigan. This is a contest whereby the loser presents the winner with a gift at the Annual AMA Auxiliary Convention in June. If we lose—Heaven forbid—we must present Michigan with two tickets to the Indianapolis 500. If we win, they must give us a comparable gift. So, you see, we need everyone's participation. It is not only the membership chairman's responsibility; it is everyone's job! No matter who wins, we have all worked together for a cause, and the Auxiliary as a whole is the true winner. By increasing membership, we will communicate with and inform more people about health issues.

Our Long Range Planning Committee has recommended that a new membership category be considered for the state Auxiliary. It would be called an associate membership. It is proposed that an associate member would be the spouse of a physician who is eligible but who is not a current dues paying member of the ISMA. As it is now proposed, the associate member would pay the same dues as does a regular member but could not hold the offices of president nor president-elect. This is just the spouse who through her or his increased awareness, knowledge, and involvement may be able to convince the physician spouse to join the ISMA. Several other states and the AMA Auxiliary have now included this category of membership. The issue will be voted upon by our delegates at our annual meeting in April.

Now, I would like to present you with three challenges. Would you join hands with us—your Auxiliary—in three areas of interest?

1. Would you consider appointing an ISMA Advisory Committee to the ISMA

Auxiliary? The Auxiliary president and president-elect could meet with this committee on a routine basis throughout the year to discuss issues, concerns, and implementation of programs of mutual interest. Maybe your president, chairman of the Board, and a current trustee could serve on the committee.

- 2. Would you consider working in partnership with us in developing "A Day at the Capitol" for our interested members and spouses throughout the state?
- 3. Would you consider assisting us to set up a program to "Spread the Word" about ISMA and Auxiliary memberships? How about helping us in sponsoring Auxiliary meetings at the same time as your district meetings? This suggestion came from your summer leadership conference. We think it is a great idea and want to help develop it into a reality. We believe there are many potential members in these settings. Our president, president-elect, and area vice president in the district would probably be the board members involved in this "reaching out" activity.

Thank you in advance for your consideration of these important matters.

# Address of the Student Council President, Indiana University School of Medicine

**Todd Taylor** 

**ACTION:** Filed.

There are two kinds of people in the world: those who make things happen and those who say "what happened?" I would like to compliment the ISMA and the House of Delegates for being among those in medicine making things happen.

Busy as we are, medical students are also very concerned and interested in the future of medicine. Over this past year, three groups have been working on various aspects of student involvement with the ISMA. The first group is the ISMA Ad Hoc Committee on Student Representation, chaired by Dr. Bill Beeson. The second group includes former student delegate Steve Foley and current delegate Gordon Hughes, who have been active in the formation of a medical student society. The third group is the Indiana University School of Medicine Student Council Committee on Student Involvement with the ISMA. Recommendations from that committee were reviewed by the Medical Student Council and have been forwarded to the ISMA Ad Hoc Committee on Student

Representation for their review and subsequent action.

If student interest and involvement with the ISMA is to continue, it will require continued and increasing commitment by both student groups and the ISMA as a whole. The Medical Student Council encourages this involvement and would like to thank Dr. Lukemeyer for his special assistance over this past year on student ISMA issues. Let's continue to work together to make things happen in medicine.

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### Report of the Executive Director

ACTION: Filed.

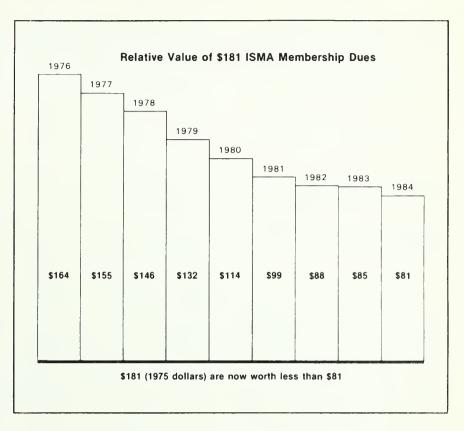
(See Res. 84-14, "Dues Increase")

Without the financial security of an increasingly solid monetary base, your Association cannot grow, cannot assert the kind of leadership that is clearly necessary to implement aggressive programs and effect appropriate changes in the provision of medical care to this and the next generation of Hoosiers.

Your Association survived the past nine years without a dues increase partly because of the fact that membership dues constitute only about 54% of ISMA's total income, and partly because of investment income and other miscellaneous sources (advertising, convention exhibits, administrative services, etc.). But it was mainly due to the efficient management of finances and personnel that your Association was able to underspend the budget, while increasing membership programs and benefits, during Fiscal Year 1983, even though we experienced 76% cumulative inflation in the general economy since 1975. However, in Fiscal Year 1983-84, the Association is working under a projected deficit budget of \$35,000.

The current dues level of \$181 was established in 1975. In 1982 the House of Delegates approved a special purpose, two-year dues increase of \$25 which expires this year (1984). As a consequence, ISMA dues for 1983 and 1984 were \$206 but will revert back to \$181 in Fiscal Year 1984-85 without further action by the House of Delegates.

Before leaving the issue of the special two-year dues increase, 1 believe you should know what happened to the money in the special dues account. A total of \$240,000 in dues money has been collected thus far from 1982 and 1983 dues payments. The ISMA expended approximately \$30,000 in legal fees from the account in obtaining legal advice on whether to litigate the Blue Cross and Blue Shield V1P program, leaving a balance of some \$210,000. And just recently the Board of Trustees approved a two-year, \$200,000 public relations program consisting of positive media messages designed to position physicians as patient advocates in the public's mind. The Board further



authorized an expenditure of \$88,000 for the current fiscal year to fund the initial phase of the campaign to be charged against the special dues account.

Now let's take a look at the \$181 dues structure of 1975 and see what inflation has done. Applying an inflation factor of 76% against the \$181 dues reveals that the 1975 dues are worth \$81 in 1984. The accompanying bar graph illustrates the erosion that took place during the period 1975/1983 due to inflation alone.

In order to support the Association's increasing level of activities and programs for fiscal year 1984-85, the Executive Committee is recommending a \$54 dues increase which would raise ISMA dues from \$181 (the 1975 level) to \$235. Recognizing the importance of the legislation and regulations on medical practice, this would permit the Association to hire two new legislative assistants and an additional half-time staff equivalent in public relations.

Some of the projects that the ISMA officers, commission members and staff are currently involved in include: a review of the mechanisms of direct and indirect advertising of medical services in Indiana;

developing a presentation to inform the membership about such alternative medical care delivery systems as HMOs, PPOs, and IPAs; a statewide public information campaign positioning physicians as the patient's advocate; developing a Peer Review Organization for Indiana; review of the Patients' Compensation Act by the Malpractice Advisory Committee in order to develop recommendations for changes that may be necessary; meeting with senior citizens' groups to discuss problem areas such as health care costs and explaining Medicare; lobbying on important national and state issues such as Medicare assignment; monitoring the DRG Program, etc. These special projects and programs involve specific issues and events of immediate concern to the membership and are being addressed in addition to the routine activities of your Association.

Commissions and staff members continue to work in such vital areas as monitoring meetings of the Medical Licensing Board and the State Board of Health, and reviewing all state and federal rules and regulations which could affect medical practice. ISMA is active in the

### Report of the Executive Director

areas of sports medicine and Indiana's high school athletes, geriatrics and nursing homes, public health, continuing medical education, members' health, life and professional liability insurance and financial planning, public relations, and

You will be interested to know that the

proposed dues increase of \$54 will still keep ISMA's fiscal year 1985 dues below our neighboring state associations which are as follows:

> Illinois - \$253 Michigan — \$290

Ohio - \$240

Kentucky — \$300

If you have any questions regarding any aspect of ISMA finances, please contact any of us at ISMA headquarters. A more detailed presentation will be made to the Reference Committee at the ISMA annual meeting in October.-Donald F. Foy, Executive Director

### Report of Chairman, Board of Trustees

Report prepared prior to Convention ACTION: Filed.

The Board of Trustees held its first meeting following the annual convention in Evansville on Nov. 20 at the headquarters, launching itself into another year of activity concerning the many issues confronting organized medicine.

In my report to you I will cover the actions of the Board which, in my estimation, were somewhat more significant than others. It was an extremely busy year for the Board, and all of the trustees and alternate trustees contributed wisely and conscientiously to the multitude of issues brought before them.

Upon the recommendation of the president, the Board approved the establishment of an ad hoc Peer Review Committee, which was charged with studying and developing recommendations for the Board regarding a PRO proposal and application which would be submitted to the Department of HHS. In a later action the Board authorized a loan of \$59,860 to the Indiana Peer Review Organization for the development of a PRO application for Indiana.

The chairman of the Health Facilities Council was invited to speak to the Board concerning Resolutions 83-31, 35 and 36, all of which related to nursing home issues. Areas of concern included 1) excessive rules, 2) legal penalties, and 3) fiscal impact. All the resolutions were referred to the ad hoc Geriatrics Committee.

Much discussion was held during the year regarding the Medical Licensing Board's system of suspending privileges; as a result, the Board suggested a joint

meeting between the MLB and the ISMA leadership to discuss procedures in license suspensions.

Depletion of the Patients' Compensation Fund was monitored by the Board. Such a depletion would result in a substantial increase in the surcharge for the fund. The Board was also informed that in the case of Wamich vs. Cha. et al., the opinion of the Jasper Superior Court held that the Indiana Malpractice Act is unconstitutional, which was indeed a serious development. The Board authorized legal counsel to file an amicus curiae, and/or participate where appropriate in an appeal.

In later actions the Board went on record to oppose provisions in any bill that would allow a malpractice claim to be settled outside the parameters of P.L. 146 to support 1) whatever action is necessary to maintain the integrity of the PCF, and 2) a Governor-controlled Medical Malpractice Study Commission. Because of the Board's concern, the ISMA Reports, Siebenmorgen's Notes and Indiana Medicine were used to remind the membership that they have an obligation to serve on medical review panels when requested in order to preserve the integrity of the medical malpractice law (P.L. 146); and to notify the membership of the possibility of an increase in the surcharge for the PCF. At this writing ISMA is in dialogue with the State Insurance Commissioner and the ad hoc Legislative Committee on Malpractice.

The Board supported the activities of the Students Against Driving Drunk (SADD) conference, which was jointly sponsored by Eli Lilly and Co., the Governor's Task Force and ISMA.

The Board modified the criteria for membership in the Fifty Year Club.

Recognizing Dr. Peter R. Petrich for his "outstanding leadership" as floor leader of the Indiana delegation to the AMA, the Board presented him with a plaque expressing thanks and gratitude. Dr. Malcom Scamahorn succeeds Dr. Petrich as floor leader.

Senate Bill 430 was strongly opposed by the Board. The bill would have eliminated the requirement that a person with an "unlimited license to practice medicine in Indiana fill the position of secretary of the State Board of Health." The bill, as passed, did retain that wording but made the commissioner of ISBH a direct appointee of the governor as are the members of the board of the ISBH already.

The Board also reviewed and approved the ISMA Group-sponsored Health and Dental Plans as submitted by the Subcommission on Insurance.

The Board also approved as Class A directors of the PICI Board, Doctors O'Neill, Knote, Khalouf, Haley, Siebenmorgen and Mr. Foy; and as Class B directors, Doctors Lukemeyer and Allen.

Concerning convention planning, the Board recommended that the opening session of the House of Delegates be streamlined, that the ISMA president and president-elect have a place on the agenda before other speakers, and that the House be convened earlier, i.e., noon or 1 p.m.

Frank Holden, president of Holden and Company, presented to the Board a comprehensive one-year communications program, which would emphasize the physician as an advocate for patients' rights. The Board accepted the \$200,000 proposal with fiscal responsibility ex-

### Report of Chairman, Board of Trustees

tended over a two-year period. The basic idea of the PR program originated with the Public Relations Commission's concern about the impact of the federal DRG program on quality and availability of medical care and treatment.

The Board asked the Executive Committee to submit a resolution to the 1984 House of Delegates proposing a dues increase along with specific reasons for the increase. The Executive Committee's recommendation, supported by the Board, is that dues be raised to \$235 annually.

The Board recommended that IMPAC contribute funds to Doctors Huber and Knote, who are candidates for seats in the Indiana House of Representatives.

An Executive Committee recommendation to the Board that all Indiana physicians continue to be sensitive to the financial circumstances of each patient and exercise voluntary restraint with respect to increases in fees and services, was adopted by the Board. This came in response to the AMA's request for a voluntary fee freeze for one year.

As usual, the Board heard detailed reports from our AMA delegation as they prepared to attend and participate in the AMA House of Delegates' meetings in Los Angeles and Chicago. Over 200 resolutions and many AMA Board council and committee reports were considered.

The Board reviewed mechanisms of direct and indirect advertising of medical services and endorsed the AMA policy pertaining to such advertising.

The Board was advised that Dr. Lukemeyer, as president of ISMA, had been presented with an award from the International Association of Business Communicators for the ISMA-sponsored television series "Heartbeat," currently being aired by 27 stations.

Creating a fee review council at the state level to assist constituent county medical societies in effective fee review matters was referred to the Commission on Medical Services.

Making credit card services available to the ISMA membership via the Indiana National Bank VISA card system was approved.

The editor of Indiana Medicine, formerly The Journal, made periodic reports to the Board regarding the editorial and business affairs of the publication.

Reports from both the Physicians Insurance Company of Indiana (PICI) and American Physicians Life Insurance Company (APL) were also reviewed periodically during the year. The growth of both companies is exceeding projected targets; they are deserving of the continued support of ISMA members.

The ISMA officers, trustees and alternates elected by you and the ISMA districts have worked long and hard hours again this year on behalf of our Association. Our loyal, dedicated and effective ISMA staff has done likewise and all have gone the second and third extra mile.

It has been a pleasure to have been

associated and worked with these people these past three years as chairman of the Board of Trustees. I trust the Association will join with me in expressing to each of them a hearty, well-deserved "Thank you" for their efforts.

The chairman's report would not be complete without mentioning his personal activities associated with that office. I have not only presided over the Board agenda and meetings for three years, but 1 have attended the annual AMA Leadership Conferences, all AMA House of Delegates meetings, all but three ISMA district meetings these three years, many ISMA committee and commission activities, including special workshops and legislative efforts with several trips to Washington, D.C., and participated in multiple negotiating sessions, i.e., thirdparty payors, and Medical Licensing Board. It was a pleasure to present on your behalf the Charter to the residents for ISMA's first Component Medical Society.

Lastly, I have attempted to keep the ISMA membership informed of the Board of Trustees actions and hope that all have enjoyed the opportunity to "Siebenmorgens Notes" concerning Board decisions these last three years.

I thank you all for the courtesies afforded me during my tenure in this office and I look forward to tackling the challenges before us as we work in other capacities for the benefit of quality medical care for our patients.—Paul Siebenmorgen, M.D., Chairman

# Supplemental Report ACTION: Filed.

For your information, the 1983 resolutions and the actions taken on these resolutions are printed herein.

Since writing the chairman's report for INDIANA MEDICINE, several noteworthy actions involving the Board have occurred.

The Board worked August 24-26 through an ISMA Leadership Planning Conference and regular Board meeting during which much information was gathered to be used as a source of discussion as ISMA plans for the future. Dr. Lawrence E. Allen, president-elect,

presented portions of this material in his address for some discussion and comments at this annual meeting.

The Board recommended that the 1984 House of Delegates support Resolution 84-18, which asks for a revision in the Medical Practice Law. It also recommended that the 1984 House have the opportunity to consider a resolution which would ask our state legislature to enact legislation to make it unlawful for an insurer to delay claim payments.

The Board unanimously approved the candidacy of Peter R. Petrich, M.D. (an ISMA past president) for election to the AMA Board of Trustees and approved the following AMA nominations:

Sprague Gardiner, M.D.—Distinguished Service Award

Joseph E. Walther, M.D.—Benjamin Rush Award

Martin J. O'Neill, M.D.—AMPAC Board

The Board was apprised of the fact that ISMA could have another AMA delegate if at least 75% of ISMA members are also AMA members.

The Board instructed ISMA legal counsel to prepare detailed guidelines to be used by the Commission on Medical Services for its use in developing a Fee Review Council.

The Board reiterated to all ISMA commissions/committees that no policy state-

## Supplemental Report, Board Chairman

ments be released on behalf of ISMA without prior Board approval or approval of the House of Delegates.

The Board gave its approval to ISMA joining with the AMA and certain named physicians to be plaintiffs in the suit against the government concerning the

Medicare assignment issue.

The Board gave its approval to sell the Harshman Building and asked the Future Planning Committee to develop plans to meet the needs for future ISMA staff and office space requirements.

The Board continues to work on nearly

all aspects of medicine on an ongoing basis as our Indiana physicians and their patients search for the highest quality of health in this rapidly changing, technological age.—Paul Siebenmorgen, M.D., Chairman

## Report of Chairman, Executive Committee

ACTION: Filed.

The Executive Committee met frequently. A wide variety of matters were considered and, as appropriate, either acted upon or referred to the Board of Trustees for final action.

The financial condition of the Association was monitored at each meeting. Periodically, investments and plane utilization were reviewed.

Several major renovations to the headquarters building have been considered and acted upon. These included the heating system, where a boiler had to be replaced, window replacements and roof repairs.

Three Congressional visits have been made to Washington by members of the

Executive Committee. This is a change in format from previous years when one lobbying visit was made. This year, by utilizing the ISMA plane rather than commercial flights, it has been possible for smaller groups to make the trip and the lobbying visits in one day. The total cost is expected to be about the same as previous years. We feel the more frequent, small group visits will be more beneficial for the Association. A fourth trip was planned in September.

A Board retreat was recommended to the Board. A retreat leadership conference was held in August.

The Committee thoroughly considered the 1984-85 budget. There has not been an ISMA dues increase since 1975. With the economic conditions during this period, it has really been necessary to tighten the budget. It is the Committee's belief that we have now reached the point where further tightening of the budget would lead to curtailment or abandonment of needed and desirable programs. The Committee has recommended a dues increase to the Board of Trustees. The Board will recommend a dues increase to the House of Delegates at the annual meeting.

I want to thank the members of the Executive Committee for their diligence and devotion to the Association. I also want to extend a special thanks to Don Foy, Ken Bush, Mike Huntley and all of the ISMA staff for their continuous cooperation and help.—Herbert C. Khalouf, M.D., Chairman

# Report of the Treasurer

ACTION: Referred for audit.

The following items were included in the House of Delegates packet: a) an unaudited statement of financial condition; b) 1984-1985 budget with prior period comparatives; and c) allocation of dues to functional expense.—George M. Rawls, M.D., Treasurer

## 1983 Resolutions: Actions Taken

- 83-1 FOOT SURGERY—Indiana Orthopaedic Society (Commission on Medical Services) Action: Implemented
- 83-2 COMMISSION ON MEDICAL EDUCATION BY-LAWS UPDATE—Commission on Medical Education (Commission on Constitution & Bylaws) Action: Implemented
- 83-3 INTERN & MEDICAL RESIDENT; MEDICAL STU-DENT SOCIETIES—Commission on Constitution & Bylaws (Commission on Constitution & Bylaws) Action: Implemented
- 83-4 RECOMMENDATION OF NOMINEES TO THE BOARD OF DIRECTORS OF MUTUAL MEDICAL INSURANCE COMPANY—Commission on Constitution & Bylaws (Commission on Constitution & Bylaws)

  Action: Implemented
- 83-5 QUORUMS—Commission on Constitution & Bylaws (Commission on Constitution & Bylaws)
  Action: Implemented
- 83-6 STANDING COMMITTEE OF ISMA—Ad Hoc Committee to Reduce Drunk Driving (Commission on Constitution & Bylaws)
  Action: Implemented
- 83-7 STUDENTS AGAINST DRIVING DRUNK—Ad Hoc Committee to Reduce Drunk Driving (County Medical Societies and Commission on Public Relations)
  Action: Implemented
- 83-8 AFFIRMATION OF PLEDGE TO REDUCE DEATH & INJURIES DUE TO DRUNK DRIVING—Ad Hoc Committee to Reduce Drunk Driving (AMA House of Delegates & ISMA Commission on Public Relations)

  Action: Implemented
- 83-9 NURSING HOME ADMITTANCE—Vanderburgh
  County Medical Society
  (Ad Hoc Committee on Geriatrics)
  Action: Inadvertently omitted from meeting agenda.
  Will be placed on next agenda.
- 83-10 LICENSING OF ATHLETIC TRAINERS—Indiana
  Orthopaedic Society
  (Commission on Legislation & Commission on Sports
  Medicine)
  Action: Commission on Sports Medicine actively
  pursuing.
- 83-11 RENAME ISMA SPECIALTY SECTION—Section on Nervous & Mental Disorders (Commission on Constitution & Bylaws) Action: Implemented
- 83-12 PROPORTIONATE REPRESENTATION FOR MEDICAL STUDENT COMPONENT SOCIETY—
  John A. Knote, M.D., President (ISMA Board of Trustees)
  Action: A study committee has been appointed.

- 83-13 AMENDMENT TO INDIANA INSURANCE STAT-UTES—Lake County Medical Society (ISMA Board of Trustees & Commission on Legislation) Action: Unsuccessfully attempted introduction of legislation in Indiana General Assembly. Will try again in 1985.
- 83-14 PAST PRESIDENTS/IMPACT—John A. Knote,
  M.D., President
  (IMPAC Board)
  Action: Implemented
- 83-15 PAST PRESIDENTS/COMMISSION ON LEGISLA-TION—John A. Knote, M.D., President (Commission on Legislation, ISMA President, Commission on Constitution & Bylaws) Action: Implemented
- 83-16 Not adopted.
- 83-17 NEW AD HOC GERIATRICS COMMITTEE—John A. Knote, M.D., President (ISMA President)

  Action: Implemented
- 83-18 STANDING COMMISSION OF ISMA (Sports Medicine)—John A. Knote, M.D., President (Commission on Constitution & Bylaws)
  Action: Implemented
- 83-19 Not Adopted.
- 83-20 Not Adopted.
- 83-21 ISMA APPLICATION FOR DESIGNATION AS IN-DIANA PRO—John A. Knote, M.D., President (ISMA Executive Committee & ISMA Board of Trustees) Action: Implemented
- 83-22 WORLD WATER WAGER—Lee Smith, M.D. (Commission on Public Relations)
  Action: Implemented
- 83-23 SUMMER JOBS FOR MEDICAL STUDENTS—
  Gordon Hughes, Medical Student
  (ISMA Membership Department)
  Action: Implemented
- 83-24 MANDATE FOR ADDITION TO REGULATIONS AND REGULATORY PROCESS TO THE CHARGE OF COMMISSION ON LEGISLATION—Marion & Vanderburg County Medical Societies (Commission on Constitution & Bylaws and Commission on Legislation)

  Action: Implemented
- 83-25 DISABILITY INSURANCE FORM—Ft. Wayne Medical Society (ISMA Board of Trustees and Commission on Medical Service's Subcommission on Insurance) Action: Implemented
- 83-26 STATEWIDE MEETING ON PHYSICIAN IMPAIR-MENT—Larry M. Davis, M.D. (Commission on Physician Impairment and Commission on Public Relations) Action: Implemented

## 1983 Resolutions: Actions Taken

83-27 DIAGNOSIS RELATED GROUPS (DRGs)—Delaware-Blackford County Medical Society (Commission on Public Relations and ISMA Board of Trustees)

Action: Implemented

83-28 BLUE SHIELD VOLUNTARY INCENTIVE PRO-GRAM—ISMA Board of Trustees (ISMA Executive Committee and ISMA Board of Trustees) Action: Implemented

83-29 Not Adopted.

83-30 DISTRICT MEDICAL EXAMINER SYSTEM—Lake
County Medical Society
(ISMA Legal Staff)
Action: The Ways and Means Committee of the In-

Action: The Ways and Means Committee of the Indiana General Assembly was contacted; no funding as yet.

- 83-31 PHYSICIAN PATIENT VISITS AT NURSING HOMES CONFLICTING WITH INSPECTION PROTOCOL AT THE STATE BOARD OF HEALTH, MEDICARE, AND MEDICAID INSPECTION TEAMS—Wayne-Union County Medical Society (Ad Hoc Committee on Geriatrics)
  - Action: The Indiana State Board of Health does not have the authority to make changes in the process; however, a current study is underway by the National Academy of Sciences Institute of Medicine Committee on Nursing Home Regulations.

83-32 INTRUSION INTO DOCTOR-PATIENT RELA-TIONSHIP (DRGs)—Indiana Chapter of the Association of American Physicians and Surgeons (No referral)

Action: See Res. 83-27

- 83-33 MEDICAL PROTECTIVE COMPANY—Ft. Wayne Medical Society
   (Commission on Medical Service's Subcommission on Insurance)
   Action: Implemented
- 83-34 REDUCTION IN DUES FOR RESIDENT MEMBERS

  —Resident Medical Society
  (No referral)

Action: See Res. 83-3

- 83-35 ALTERNATIVES TO NURSING HOME CARE— DeKalb County Medical Society (Ad Hoc Geriatrics Committee) Action: Implemented
- 83-36 STATE BOARD OF HEALTH REGULATIONS ON NURSING HOMES—DeKalb County Medical Society (Ad Hoc Geriatrics Committee)

Action: The law regarding sanctions and fines is not subject to change by rule or regulation of the Health Facility Council. The Committee believes the new regulations will respond to this resolution.

RESOLUTION CONCERNING LAWRENCE PATTON McDONALD, M.D.

Action: Implemented

An updated listing of ISMA trustees and alternate trustees appears on page 1072.

# First District ACTION: Filed.

Members of the First District Medical Society spent a considerable amount of time and effort to host the ISMA annual convention in October 1983 in Evansville. Delegates secured passage of two resolutions, but were unsuccessful in campaigning for Dr. Forrest Radeliff, candidate for vice-speaker.

The First District annual meeting was held May 10, 1984, at the Evansville Country Club. Presiding at the meeting was Dr. Kent McKinney, First District president. He welcomed ISMA officials and staff in attendance. Reports were given by Dr. George Lukemeyer, ISMA president; Dr. E. DeVerre Gourieux, First District trustee; and Dr. Gilbert M. Wilhelmus, AMA delegate from Vanderburgh County.

Dr. McKinney thanked Dr. Donald R. Elder, vice-president, and Dr. Jeffrey C. Rendel, secretary-treasurer, for their cooperation during the year. New officers elected at the meeting were Dr. Elder, president, Dr. Rendel, vice-president, and Dr. Gary L. Beck, secretary-treasurer. The minutes and financial statement were approved as mailed.

Dr. McKinney presented an art print to Dr. and Mrs. Bruce Romick for cochairing the committee hosting the state convention and commended them for their excellent organization. Dr. McKinney also announced the winners of the golf tournament, in which 40 members participated.

Following an excellent dinner, the audience enjoyed entertainment provided by the Evansville Musicians' Club Chorus, several of whom are First District members.

A special area of concern for First District members this past year was passage of regulations by the Medical Licensing Board of Indiana. Many of our physicians had input into drafting the regulations, which ensure the protection of Indiana citizens without endangering the practice of medicine.

We would like to thank ISMA staff for their efforts in lobbying on behalf of all members of First District. Many bills were introduced during the short session of the 103rd General Assembly. We anticipate an even greater number next year and will be encouraging members to contact their state legislators on issues affecting the medical community. We also suggest that members support the Indiana Medical Political Action Committee with their financial contributions.

We appreciate the efforts of those physicians who served on ISMA commissions. We would also like to thank Dr. Wallace Adye, Jr., alternate trustee, who is serving on the Indiana Peer Review Organization board.

Membership in First District decreased 4% to a total of 450 members as of Dec. 31, 1983; 54% of First District members belong to the AMA.—E. DeVerre Gourieux, M.D., Trustee

# Second District

ACTION: Filed.

Another year has passed with the increasing challenge of addressing the massive increase in government "involvement" in medical care. Most of us consider this an erosion and invasion of the doctor-patient relationship we have enjoyed in the past. Physicians have been "mandated" to become involved in government programs, and all the private sectors seem to be holding us responsible for properly initiating these programs. Your ISMA hopes to present the united front needed to "temper" and cope with these programs.

The years' issues confronted by your trustees, ISMA officers, and ISMA staff have always been complex and controversial but this has at least doubled now with the increase in government "involvement." During the year, we have been called a "do-nothing group." I assure you that this is not the case. The decisions are made by a group of physicians representing different geographical areas, different specialties and different personalities. This produces a wide diversity of opinions but hopefully provides a decision around which all alternatives have been intelligently considered.

A few of the year's issues are as follows:

- 1. Obviously, the most significant of these issues was the enacting of the DRG program. Space does not permit commenting adequately on this issue; however, the data, as it is coming in, seems to be showing that DRGs actually increase medical costs. Again, it will be questionable as to whether Congress will listen to the facts.
- 2. Also mandated in this temporal law was the PRO. Your ISMA has decided to shoulder the responsibility as the PRO for Indiana. Again, this was very controversial and some members are opposed to this. With this "given" bitter pill, I ask you to consider the alternative groups that are waiting to acquire this control should it not be assumed by the ISMA.
- 3. Your Board decided against litigation on the VIP program since it was thought to be floundering at this time. Also, our council could only give us a 50-50 chance of successfully opposing this.
- 4. During the year, the legislature saw fit to change the manner of selection of the director of the State Board of Health.
- 5. The Physicians Insurance Company of Indiana has thrived (much to the dismay of some members) and the malpractice crisis is again looming on the horizon. Some constituents have already reported that malpractice insurance is unavailable from some companies in the state, simply because of the risk group to which the physician belongs.
- 6. Paramedical personnel and limited licensed practitioners continue to make legislative inroads into the medical care system. Optometrists, chiropractors, nurse midwives, audiologists, pharmacists, clinical psychologists, physical therapists, nurse practitioners, podiatrists, and others are seeking legislative action to obtain admitting and clinical practice privileges inside the hospitals. Many of us feel this is inappropriate and will actually raise medical costs. Also, it will permit inappropriate hospitalizations by untrained, limited practitioners.

The preceding issues (and others) are still an ongoing controversy among your Board members and the membership itself. These can be best dealt with on a

unified front (i.c., organized medicine). The lower levels of organized medicine are becoming more important and their participation as members of the ISMA must increase in the future. The committees' and commissions' representation also must continue to improve. These efforts must be extended if we are to continue to provide the high standard of medical care that we presently practice and which is only found in the United States.

Last year, the Second Medical District meeting was held on June 29 at the Elks Club in Vincennes. Dr. Frederick Buehl presided, with Dr. Roscoe Vaughn serving as secretary-treasurer. The informative presence of the ISMA officers and ISMA staff was greatly appreciated and enjoyed. A program of "Physician Burnout" was presented to the membership and their spouses. The 1984 meeting will be hosted by the Daviess-Martin County Medical Society in Washington, Ind. Dr. James Beck will serve as president and Dr. Robert Heymann as secretary-treasurer.

Dr. Paul Wenzler and I continue to represent your interests at the regular ISMA Board of Trustees meetings as well as at special sessions and the annual ISMA convention. We would like to express our thanks to the membership of the Second Medical District for allowing us to represent them as trustee and alternate trustee. I am looking forward to representing you three more years as trustee, if re-elected this summer. Thanks also go to the excellent ISMA staff for their continuing beneficial assistance throughout the year.—Ralph W. Stewart, M.D., Trustee.

# Third District ACTION: Filed.

As your trustee, I have attended all Board meetings and would encourage members with any current concerns to contact me and to keep abreast by reading ISMA Reports, Board reports and INDIANA MEDICINE.

Our district meeting was held April 27-28, 1984 in New Albany. A panel discussion of pertinent ISMA issues was moderated by Dr. Everett Bickers, president. The panel consisted of ISMA

district and state officers and ISMA staff. Officers elected for 1984-85 were Dr. Wallace Johnson, president, and Dr. Peter Livingston, vice-president. Lawrence County will host the Spring 1985 meeting.

The Board is constantly reviewing reports and actions taken by the Executive Committee, commissions and committees, AMA delegates, Medical Licensing Board actions, Physicians Insurance Company of Indiana and American Physicians Life, as well as others. Some of the highlights during this past year are listed below.

**ISMA Income**—54% from membership, 21% from interest, and 25% from ads, airplane usage, annual meeting, etc.

**ISMA Expenses**—43% for salaries and benefits, 12% for travel, 5% for building, 12% for printing and 28% for phones, postage, insurance, etc.

**Dues Increase**—At the annual meeting, a dues increase will be considered for 1985. We must seriously consider a dues increase if we are going to continue the kind of programs we have been providing.

Indiana Physicians Review Organization (IPRO)—Indiana physicians have formed and funded the initiation of IPRO and by the time of our annual meeting, this organization may possibly be existing and functioning.

Mandatory Medicare Assignments— This bill was defeated thanks to physicians throughout Indiana who called their congressmen, and ISMA and AMA lobbying efforts.

**Public Relations**—ISMA funds available from our last two years' special dues will be used for public messages that will emphasize the physician as an advocate of patient rights.

Medical Liability—We have learned that claims are increasing. The surcharge has been increased and ISMA will need to continue monitoring the Patient Compensation Fund.

Legislative Issues—ISMA members and staff spent a considerable amount of time on legislative issues this year, which is an important function of our organization. One of the bills that is now affecting us all is the Generic Substitution Bill.

1 encourage all counties in our district to make sure that their delegates are ready for our annual meeting in Indianapolis Oct. 19-22. We will no doubt be discussing the dues increase, emergency and/or satellite clinics, plus various other reports and resolutions.

At our 1983 meeting, we did have delegates representing Clark, Floyd, Lawrence and Harrison-Crawford counties. There was no representation from Orange, Scott and Washington counties. We look forward to seeing all these counties represented at our fall meeting this year.

I really enjoy the opportunity to serve as your district director and if you should have any concerns at any time, please write or call. I do visit some of the county medical society meetings and will be attempting to do more of this.—R. G. "Dick" Huber, M.D., Trustee

# Fourth District ACTION: Filed.

The Fourth District Medical Society held its annual meeting on May 30, 1984 at the Madison Country Club in Madison. I would like to give my sincere appreciation to Dr. Howard Jackson and Dr. George Alcorn, as well as the members of the local medical auxiliary in Madison for providing such a wonderful day of entertainment for the guests. The evening speaker at the dinner was Dr. Walter Daly, dean of the 1.U. School of Medicine. Golf awards and tennis awards were given. The meeting next year will be held in Columbus. Newly elected president of the Fourth District will be Dr. William Cooper. Other officers were also elected that day.

The past two years, the Fourth District Medical Society has elected a floor leader to guide the members during the annual meeting in October. Elected again this year as the Fourth District floor leader was Dr. Ed Probst of Columbus.

This past year has been very significant in regard to many issues concerning organized medicine. The ISMA Board of Trustees has taken a very progressive approach in confronting many of the problems facing us at this time. I was quite pleased to participate and vote for the new public relations program which will be carried out in Indiana. I feel that this

is a very wise use of our funds and if the medical profession is to stay in the forefront as a free enterprise organization, this type of public relations is quite necessary.

Another issue confronting us during this next year will be that of a dues increase and consideration of either renovating or obtaining a new building. Although a dues increase is never fun, I think that one will be necessary and the Board of Trustees is recommending this to the House of Delegates during our annual meeting in October.

Finally, I feel that the most important concern facing us this year, as in the past several years, is malpractice. The most progressive step taken by our organization in the last several years has been the formation of the malpractice insurance company. This is a growing company and as we look at the annual increase of members making use of this malpractice insurance, we can see that it is growing quite readily. I would urge everyoneevery member of the Indiana State Medical Association—to consider purchasing this malpractice insurance in the future. This is the main hope that we have to control malpractice costs in this state, and it is to everyone's advantage both financially and politically to carry their malpractice with this company. Even if you had another carrier in the past, I would urge you to at least obtain quotations on prices from our new company. Their prices are competitive and when you obtain a total bid from any other company, the State Medical Association's will be as low as any fee charged.

I have enjoyed to continue being trustee of the Fourth District and hope that I can continue serving my district well on the Board of Trustees.—Mark M. Bevers, M.D., Trustee

# Fifth District ACTION: Filed.

At press time, the Fifth District has scheduled its annual Medical Society meeting for Sept. 5, 1984 at the Windy Hills Country Club in Greencastle, with James Johnson, M.D., president, presiding and Peggy Sankey Swaim, M.D., secretary-treasurer, again handl-

ing the financial affairs. With the incomparable John Talley, M.D., as the scheduled feature speaker, a large turnout is expected once again.

Last fall's Fifth District meeting in Terre Haute was well attended and district members had an excellent opportunity to discuss their medical concerns with a large group of ISMA staff and officers including John Knote, M.D., then president of ISMA.

The report of the activities of the Fifth District trustee can best be reviewed by reading the "Chairman of the Board of Trustees Report," as I have functioned in that capacity for the last three years. I have completed the limit of two consecutive terms and, according to ISMA Bylaws, am not eligible for re-election. Therefore, there will be a new trustee elected at the Fifth District meeting on Sept. 5, 1984.

It has been a pleasure and a distinct honor to have been able to serve as your Fifth District trustee these last six years and I have tried to present your views in all pertinent discussions. I thank you for that opportunity. I must also thank Howard Grindstaff and Sara Klein, ISMA field staff, for their excellent help through the years and must give a special thanks to Benny Ko, M.D., our Fifth District alternate trustee, who has done a yeoman's job on behalf of our district on numerous occasions and particularly when I have been occupied with other ISMA responsibilities.—Paul Siebenmorgen, M.D., Trustee

# Sixth District ACTION: Filed.

The annual meeting for the Sixth District Medical Society was held in Shelbyville this year on Wednesday, May 16, 1984. The Shelby County Medical Society did a fine job of hosting a golf outing at the local Elks Country Club. Mrs. Paul (Joan) Inlow and other auxiliary members hosted a special women's afternoon program, while the physicians joined for the business session. State officers and staff were present and provided commentary on current medical/political situations.

New officers for the Sixth District Medical Society are as follows: President, Dean Felker, M.D., of Greenfield; Vice President, Douglas Carter, M.D., of Shelbyville; Sec'y/Treasurer, Douglas Morrell, M.D., of Rushville.

The business meeting and evening dinner were held at the Holiday Inn. Guest speaker Jack Fadely of Butler University provided a well received after dinner program.

Attendance was representative but not great considering the overall membership. General interest and participation remains a problem. I'm sure that this topic will be considered at the coming leadership conference in Indianapolis late in August.

My thanks to Alternate Trustee Clarence "Bud" Clarkson for representing me at the Sixth District Medical Society annual meeting.—Davis W. Ellis, M.D., Trustee

# Seventh District ACTION: Filed.

As we prepare our 1984 report, plans are being finalized for this year's Seventh District meeting. Continuing the trend set for us last year, the '84 meeting will highlight a unique social opportunity for the members of the District, their spouses and friends. This year's meeting will feature dinner and entertainment at "Crackers", which is Indiana's only permanent comedy club.

The '83 meeting of the District was held prior to an evening of entertainment at the Cabaret of the Indiana Repertory Theater. Dr. Warren Gray of Martinsville, President of the District, conducted the annual business session, which contained several routine business matters. Representatives of ISMA who were recognized included Dr. John Knote, ISMA President, Dr. Lawrence Allen, then Speaker of the House, Dr. Shirley Khalouf, then Vice-Speaker of the House. Also, introduced were the numerous other representatives of ISMA in attendance, including Seventh District representatives and AMA Alternate Delegates, Dr. Arvine Popplewell and Dr. Alvin Haley.

In District elections, Dr. Donald J.

Kerner of Indianapolis was chosen President-Elect of the Seventh District, and Dr. Malcolm Scamahorn was reelected to the position of Secretary-Treasurer.

Dr. Donald C. McCallum was recognized for his ten consecutive years of service, first as an Alternate Trustee, and then as a Trustee of the Seventh District, and Dr. John D. MacDougall was promoted by election from his Alternate Trusteeship to succeed Dr. McCallum. Dr. William H. Beeson was elected to succeed Dr. MacDougall and complete his term as an Alternate Trustee. Trustees are looking forward to an enjoyable evening for the '84 District meeting on August 16th.

The physicians of the Seventh District and the entire state owe a debt of gratitude to Dr. George T. Lukemeyer for his leadership as President of the ISMA for '83-84. Those of us from Marion County and the Seventh District benefitted from Dr. Lukemeyer's direct participation and leadership for a number of years, and are pleased that George could provide this same leadership to the ISMA, first as an AMA Alternate Delegate, Delegate, President-Elect and then as President of the ISMA. We extend a hearty "Thank You" to George for his efforts over these many years. We are pleased to think that he will continue to provide his advice and counsel as a Past President of the ISMA.

#### PERSONAL NOTE:

First as an Alternate Trustee and during this past year as a Trustee, I have enjoyed working with Sandy Trusler in his role as a Trustee from this District. Sandy has declined to continue as a Seventh District Trustee and will leave the position at the end of the '84 ISMA Convention. We regret that the District and the ISMA will lose his dedication to representing physicians, but are pleased to know that his continued dedication to organized medicine will assure his availability for consultation in the future. Sandy, the members of the Seventh District thank you for the many hours of dedicated service and leadership you have provided on our behalf.-John D. Mac-Dougall, M.D., Trustee

# **Eighth District ACTION: Filed.**

1983-84 has been a very busy year. As trustee, I have had to consider many different issues of importance to the future of medicine. Diagnostic Related Groups (DRGs) have been discussed at length. Peer Review and ISMA's position in respect to the Peer Review Organization has been considered. It was my opinion, after reviewing available data, that ISMA should not be directly involved in that process and this was the position of the Board of Trustees.

Another item of discussion has been the development of a public relations campaign under the direction of an established, high-quality consulting firm. The small pilot program has begun with the Commission on Public Relations approving the final drafts prior to release to the media. It is my belief that a larger campaign should arise from this pilot program.

The annual meeting of the Eighth District Medical Society was held at the Anderson Country Club on June 7, 1984. The meeting was well attended by members of the district and ISMA officers and staff. A lengthy and informative business meeting ensued and was concluded by the election of William Van-Ness, II, M.D., as trustee and Douglas A. Triplett, M.D., as alternate trustee, both becoming effective in October 1984. Officers for the Eighth District Medical Society for the 1984 year were: president, Charles Bartholome, M.D.; secretary/ treasurer, Stephen R. Miller, M.D.. The 1985 meeting date will be June 5 or 12, 1985, at the Delaware Country Club. An excellent dinner was enjoyed by everyone in attendance and Stephen Goldsmith, Marion County prosecutor, was the afterdinner speaker.

This is the last year of my term as Eighth District trustee. I wish to thank the members of the district for extending me the opportunity to serve in that capacity. It is my intention to remain active in ISMA affairs and would urge all physicians in my district to assume a more active role in the political affairs of organized medicine. Thus, through a united effort, we will be better able to preserve the highest level of medical care for our patients.

In conclusion, I wish to thank the entire ISMA staff for their exceptional performance of duties during the past year.

—Richard L. Reedy, M.D., Trustee

# Ninth District ACTION: Filed.

During the past year, we have again been made keenly aware of attempts by the federal government and third-party insurance carriers to standardize and regulate providers of medical care. As a result of these attempts to invade and control, I am pleased to report that Ninth District physicians are making a positive response. This is evident by an increase in support of IMPAC. I strongly urge those who are not yet members to join and participate by voicing your desires to state and national legislators. This is where we must work for the preservation of free enterprise and medicine.

We physicians in the Ninth District are fortunate to have many interested and willing to spend time and assist the leadership of ISMA in developing policy and speaking on our behalf. Our commission and committee members have served us well and we are grateful for their efforts. A prime example was the excellent seminar and subsequent development of a program now available to assist impaired physicians in our state. Again, this represents a positive approach taken in response to a problem that is evident.

Our Ninth District meeting was held in Rensselaer on June 12, 1984 and hosted by Dr. Robert Darnaby and other Jasper County physicians. They provided an excellent setting at the Curtis Creek Country Club and those in attendance were treated with an updating and informative discussion led by Dr. Lukemeyer and the ISMA staff. The after-dinner speaker, former governor Otis Bowen, M.D., spoke on "Medicine of the Future." He predicted an increasing rise in medical care costs due to the evident increasing age of our population and demands for top priority care. He also predicted increasing efforts by the government to control costs. In response, he recommended that physicians continue to upgrade their knowledge in medicine with

continuing medical education, spend part of their time in community service and actively participate in the political process.

I am grateful for the opportunity to serve as your trustee and continue to welcome your comments as we attempt to represent each of you on the ISMA Board.—Max N. Hoffman, M.D., Trustee

# Tenth District ACTION: Filed.

Dr. Mary Carroll completed 1983 as president of the Lake County Medical Society and is followed by Dr. Barron Palmer for 1984. In Porter County, Dr. John Swarner was 1983 president, presently followed by Dr. James Malayta.

The Medical Care Share program implemented by the county society for Residents in Temporary Need of Medical Services has been highly successful. Some 60 physicians have volunteered services and approximately 50 people per week have participated in this program in Lake County.

With the changing insurance regulation legislation in 1983 and 1984, concerns regarding HMOs, 1PAs, PPO systems and other reimbursement arrangements are surfacing. As a result, the Lake County Medical Society sponsored a program with representatives from major local industries and their insurance carriers to describe their changes in benefits and eligibility criteria. This was a well received liaison with all parties concerned and some 100 physicians attended.

The Tenth District Golf Outing was held at Briar Ridge Country Club in September with the meeting, followed by dinner, at Woodmar Country Club. Dr. Vincent J. Santare was elected Tenth District president, Dr. Charles D. Egnatz was re-elected trustee, and Dr. Walfred A. Nelson was re-elected alternate trustee. Mr. Dan Hill has accepted a position as executive director of Lake County Medical Society. Mr. Hill is an attorney, previously on the staff of the American Medical Association and the staff of the American College of OB-GYN.

The 1984 Tenth District meeting, which will have been held by this printing, is ex-

pecting Peter Visclosky, the Democratic candidate for U.S. Congress from the First District, as the guest speaker. This position is presently held by Katie Hall and previously held by the late Adam Benjamin.—Charles D. Egnatz, M.D., Trustee

# Eleventh District ACTION: Filed.

The Eleventh District Medical Society met at the Wabash Inn on September 21, 1983. There was good attendance at the business meeting and for dinner. An interesting after dinner program was presented by Ed Ziegler, a political columnist. My thanks to the Wabash County Medical Society for an excellent meeting. A word of thanks to the ISMA official family for their attendance and participation. This year's meeting will be held on September 19, at the Grissom Air Force Base and will be hosted by the Miami County Medical Society. We are looking forward to an interesting and unusual program.

The Board has had another busy year. Each year, it seems, new challenges face physicians and organized medicine. Most of these come from government and this year is no exception with DRGs and PRO.

The Board, at the direction of the House of Delegates, has hired a public relations firm. A public relations campaign entitled, "Positioning Physicians as Patient Advocates," has been developed and is being implemented. There will be newspaper, radio and bill-board ads throughout Indiana. The total program will cost \$200,000.00. The first phase, costing \$88,000.00, is underway. The program will be evaluated and, if satisfactory, continued. This may very well be one of the more important and hopefully productive things done by our association.

The Board has funded the Indiana PRO as authorized by the House of Delegates. The Indiana PRO, by government regulation, had to be a separate, arms length entity from ISMA. There were mixed feelings concerning this issue. When one considers the alternatives if organized medicine didn't do this, the

Board's action becomes very reasonable. At the time of this writing, the Indiana PRO has been certified. It is anticipated that they will be able to repay the money loaned them.

ISMA has not had a dues increase since 1975. When one considers what has happened to the value of the dollar over this period, it is quite remarkable. We are now at the point where a dues increase is mandatory if ISMA is to maintain and implement programs that we need and want. A dues increase will be recommended to the House of Delegates at the Annual Meeting.

I, again, have had the privilege of being on the Executive Committee and serving as its chairman.

I want to thank the members of the Eleventh District for allowing me to serve as your Trustee for the past seven years. I have thoroughly enjoyed it. There have been times that I have been very discouraged by the continuing attacks on medicine and doctors. My time on the Board has convinced me that we and our patients benefit from the activities of organized medicine. That's really what it's all about.—Herbert C. Khalouf, M.D., Trustee

# Twelfth District ACTION: Filed.

1984 has been an eventful year for medicine, both in Indiana and nationally. Indeed, with the many legislative and regulatory changes, medicine in 1984 has certainly taken on an Orwellian flavor.

Nationally, the specter of mandatory assignment has receded only to be replaced by the Deficit Reduction Act of 1984. A product of a joint-conference committee, this legislation asks each physician to decide whether to participate voluntarily in mandatory assignment or to decide on a case-by-case basis, thereby becoming a non-participating physician.

Any change is painful. This is particularly so when it involves proposed restructuring of the most effective system of delivery of health care ever developed. The only positive aspect of the current political climate is that we, as physicians, find ourselves even more squarely in alliance with the best interests of our pa-

ticnts. The government has declared allout war on health care costs with no regard for quality or accessibility. You only have to look as far as the problems of nurse staffing at your local hospital to see the effect DRGs have had on hospital administration. The only people concerned with quality are the patients receiving the care and physicians providing that care. Your Board of Trustees feels the public must be made aware of this situation and has made a major commitment in this area.

Dues increases are never popular. I refer you to Don Foy's article in the August 1984 issue of INDIANA MEDICINE for background information on the need for the increase. Essentially, we are the only state association not to have had a dues increase since 1975, and even with the increase, will be below all four of our neighboring states. We have been able to postpone a dues increase until now by a combination of belt-tightening by the Executive Committee, and excellent management of staff.

A word about staff: We are fortunate to have a nucleus of extremely qualified and knowledgeable people. They are quality people and they work hard to represent you. In fact, they are spread too thin. With the passage of the proposed increase, we will be able to employ two new legislative assistants and an additional half-time staff equivalent in public relations. This will free our field representatives to do just that.

As of this writing, hearings are being held by the Malpractice Legislative Study Committee. We have real problems with the Patient Compensation Fund. We are in desperate need of claims review with an attempt to isolate medical causation from damages. Contracting with the claims supervisor might provide for this need and we feel would be within the framework of existing legislation. Structured, i.e., periodic, payments for the first \$100,000 of a claim with co-existing immediate payout from the PCF for the remainder of the claim is clearly not what our 1975 legislators had in mind when the Medical Malpractice Act was passed. And, finally, the average payout from the PCF is in excess of \$300,000. Logic seems to dictate that somewhere, at some time, there must be a claim in Indiana worth more than \$99,000 and still less than \$400,000.

The Twelfth District Medical Society annual meeting was held at Holiday Inn Downtown in Fort Wayne on Sept. 20. Marion County Prosecutor Stephen Goldsmith was our featured speaker. Antonio Donesa, M.D., was elected president; Thomas Smith, M.D., vice-president; and Mark Souder, M.D., secretary/treasurer.

I would like to express my thanks to the membership of the Twelfth District for electing me to serve as trustee and look forward to doing so in the future.— Michael O. Mellinger, M.D., Trustee

# Thirteenth District ACTION: Filed.

The Thirteenth District Medical Society had their successful 1983 annual meeting at the Elcona Country Club in Elkhart. The meeting was fairly attended and the evening session was very well attended, with over 180 people at the meeting. It has been a problem to attract members of the district medical societies to attend the business meetings which are held at 5:30 in the afternoon.

Twelve years ago, Dr. Frank McGue, then president of the Thirteenth District Medical Society, instituted a golf outing to attract the doctors early in the afternoon and entertainment in the evening to increase the attendance. This has worked out fairly well, but the attendance at the business meetings needs to be improved. It is at these meetings that we elect our district officers who represent physicians in the eight counties of the Thirteenth District at the state level.

Dr. Richard Green of South Bend was elected president for 1984 and Dr. B.V. Tiscay of Michigan City was elected president-elect for 1985. Dr. Don Chamberlain, our trustee for six years, retired and Dr. John W. Luce of Michigan City was elected trustee of the Thirteenth District Medical Society. Dr. Steven Yoder of Goshen was elected alternate trustee to fill the unexpired term until 1985.

This year's annual meeting will be held Sept. 12, 1984, at the Knollwood Country Club in South Bend. The St. Joseph County Medical Society will be the host society and activities are planned for the day including golf, spouses' programs, door prizes, dinner and a guest speaker.

of Trustees. One of the problems facing us was the deficit budget that was proposed by the Executive Committee. We have not had a dues increase since 1975 and we all know what inflation has done to the value of the dollar. With increased activities and operations, the State Medical Association has been able to hold the line in the budget with outside investments. In 1984, we are faced with a \$30,000 deficit budget and a dues increase will be proposed to the House of Delegates in October 1984.

Another problem that was resolved by the Indiana State Medical Association was the establishment of an Indiana PRO. This was mandated by the House of Delegates in 1983 and Dr. Muller's committee has been working hard on establishing its acceptance by the HCFA. The proposal, introduced by Indiana's PRO, was accepted on a basis that they amend some of the proposals to satisfy HCFA's regulations. Fifteen states have been denied PRO contracts because of their proposals, and it is hoped that this will be finalized by the Oct. 1, 1984 deadline for PROs. This will keep the peer review of the DRGs in the hands of the physicians and not unqualified sources. It is hoped by the Board of Trustees that the physicians in the districts will cooperate with PRO and volunteer to sit on these panels for medical reviews. The funding of the Indiana PRO was done by the ISMA and it is hoped that we will recoup the start-up expenses which are in excess of \$60,000 this year from the monies that will be obtained by the PRO for their work.

Dr. George Lukemeyer, president of ISMA for 1984, has been an inspirational leader and has put many proposals on the table for the State Medical Association to implement. He has also been helped by the president-elect, Dr. Lawrence Allen of Anderson. With the coming of more federal regulations and DRGs even from the private insurance carriers, the physicians of the State Medical Association voted to endorse the AMA's physi-

### **Reports of Trustees**

cian fee freeze for 1984. Whether this will be effective or not remains to be seen. Placing the blame of inflation upon physicians' fees when the federal budget deficit is over \$200,000,000,000 is incongruous.

In 1984, I have instituted a policy of writing letters to all the eight county medical societies after each Board of Trustees meeting, informing the constituents as to what business took place at the

Sunday meetings. I have also visited several of the county medical societies, giving them verbally first-hand information as to what happened in Indianapolis. Dr. Steven Yoder has also visited several of the county medical societies in the eastern part of the district doing the same thing. I intend to continue this policy of writing letters after each Board of Trustees meeting, as I feel the members of the Thirteenth District Medical Society

should be up to date on what is happening in the Board of Trustees and Executive Committee of the State Medical Association.

I have enjoyed my first year as a full trustee. I am looking forward to cooperating with Dr. Larry Allen next year and the other members of the Board of Trustees. I hope to continue to have access to all members of the district.—John W. Luce, M.D., Trustee

### Report of the AMA Delegation

Submitted by: AMA Delegation

ACTION: Filed.

Indiana delegates to the 1984 annual meeting of the AMA House of Delegates in Chicago, June 17-21, were among 355 delegates representing the state medical associations and national medical specialty societies.

The House considered 182 resolutions and 73 reports, all of which were reviewed in detail prior to the meeting by the Indiana delegation and closely watched at the meeting as they were considered in Reference Committees and in the House.

The Delegation was in full attendance starting with Saturday's caucus with the Great Lake states. Other caucuses were held to discuss assignments, reference committee works and reports on political races. A Saturday night dinner at Metro Club was a highlight social event as we hosted our national Auxilians. This is an evening of friendship for our members, their spouses and guests.

In response to the Indiana delegation's resolution which asked for the elimination of the "unnecessary and demeaning" statement in the (DRG) regulations that require physicians to certify primary and secondary diagnoses and procedures, the House voted to continue to exert strong and concentrated efforts to accomplish the objectives of the Indiana resolution.

In other actions relating to DRGs, the AMA House voted to:

• Seek legislative and regulatory changes to ensure that differences in

DRG-based payments to different categories of hospitals (rural and urban) are based on true differences in the costs of providing services by those hospitals rather than on arbitrary geographic criteria.

- Oppose the mandated algorithmic or cookbook/decision tree method of establishing a treatment regimen as cost effective under the Medicare payment system.
- Oppose the expansion of DRGs to physicians.
- Seek changes in the DRG system to provide adequate reimbursement for events arising during hospitalization that significantly add to a patient's requirements for care.

Some of the other important actions of the AMA House included the following:

### **New Liability Crisis**

Concern with the "new liability crisis" prompted three AMA resolutions, one of which called for the AMA to create a formal organizational staff effort to respond to the problem. AMA Executive Vice President James Sammons, M.D., addressed the House on the issue reporting that the AMA is currently trying to gather data on the issue, but has experienced difficulty in obtaining data from the insurance industry. "We are constantly working on this issue that cuts across many areas in the AMA," Dr. Sammons stated. The delegates voted to refer the matter to the Board "with high priority." Another resolution was passed asking the AMA to assist state medical societies in forming coalitions to support tort reform in each state and to educate the public regarding the impact on and cost to consumers of current liability laws. Additionally, a Special Task Force on Professional Liability was formed to coordinate and expand AMA activities in this area.

### AMA Finances and Membership

The House approved several recommendations of the Board of Trustees contained in a major report about AMA finances and membership.

- Of foremost interest to AMA members is that AMA dues will be maintained at current levels in 1985. The Reference Committee cautioned the House, however, that future AMA dues may have to be increased by \$30 in 1986 and an additional \$30 in 1987 in order to avoid major reductions in AMA programs and activities in those years.
- State medical associations will be allocated one extra delegate when 75 percent or more of the state society's members are also AMA members. Unified states (Illinois and Oklahoma) will be granted two additional delegates.
- The dues exemption policy was revised so that this membership category is limited to members who are at least 70 years of age and fully retired or suffering financial hardship and/or disability.
- Members who are at least 70 years of age and working no more than 20 hours per week pay one-half of regular dues.
  - Members who previously qualified

### Report of the AMA Delegation

for dues-exemption under criteria other than financial hardship would continue to be eligible under the grandfather clause,

#### Health Policy Agenda

A special reference committee was appointed to consider the 159 principles developed by the Health Policy Agenda for the American People,

These principles are broad value statements about what should exist in the health policy area,

Instead of adopting the principles as AMA policy, the House voted to endorse them as working principles to help guide AMA representatives to HPA Work Groups and Advisory Committees throughout the remainder of the project, scheduled for completion in 1986.

In its next phase, the HPA will translate the principles into policy recommendations and action plans.

#### Hospital Medical Staff Issues

The Hospital Medical Staff Section met for two days prior to the opening of the AMA House.

Over 700 representatives were registered from virtually every state. They considered about 60 resolutions and submitted 18 resolutions for consideration by the AMA House,

The goal is to have every hospital send a representative to further enhance communication between the AMA and local hospital medical staffs.

The AMA House approved a number of resolutions related to the organization and operation of the medical staff. The House:

- Supported the medical staff's authority to approve or disapprove all amendments to medical staff bylaws.
- Supported the idea that hospital governing boards cannot unilaterally change medical staff bylaws.
- Asked the AMA to prepare and distribute a document on the legal status of medical staffs.
- Encouraged hospitals and medical staffs to make all medical staff rules available to physicians.
- Directed the AMA to oppose any regulation that would mandate voting privileges for non-physician members of the medical staff,
  - Recommended that medical staffs

develop bylaw provisions that affirm the binding effect of medical staff bylaws on the hospital governing board and the medical staff.

#### Automobile Safety

The House considered several resolutions related to the use of air bags and seat belts. The House supported:

- Mandatory installation of air bags in domestic and foreign cars,
- Legislation promoting the availability of seat belts in all motor vehicles, including buses and taxis, used to carry passengers.
  - Mandatory seat belt use laws.
- Mandatory child passenger restraint

#### Tobacco and Health

Taking an aggressive anti-smoking stance the House approved several policies to position the Association in the forefront of anti-smoking groups. The House voted to:

- Urge Congress to strengthen warnings on eigarette packages to say that smoking causes cancer of the mouth, larynx, and lung; is a major cause of heart disease and emphysema; and is addictive; and may result in death.
- Study the safety and efficacy of nicotine chewing gum as an aid to smoking cessation.
- Ask the Surgeon General to place health hazard warnings on all snuff and chewing tobacco packages.
- Encourage physicians to schedule extra time to explain the health hazards of smoking to their patients.
- Urge hospitals, offices, and all other medical care facilities to declare themselves off-limits to smoking.
- Work to protect the health of nonsmokers on airplanes.

Doctor Joseph Walther, Indianapolis, who is a delegate from the American College of Gastroenterology, was nominated by the Indiana delegation for consideration for the AMA Distinguished Service Award. In spite of his impressive background of accomplishments both in the medical field and the military during World War II, the award went to another nominee.

Doctors Scamahorn and Petrich were seeking reelection, respectively, to the Council on Medical Service and the Council on Constitution and Bylaws. Campaign plans made previously were followed which resulted in Doctor Petrich's reelection. Doctor Scamahorn was not reelected to a third term on the Council on Medical Service.

### Future Meetings

The Interim meeting of the AMA will be held in Honolulu, December 2-5, 1984 and the annual meeting in Chicago, June 16-20, 1985, in Chicago,

### Los Angeles, California December 4-8, 1983

The AMA Delegation met in Los Angeles for the Interim meeting of the House of Delegates with cost control, the JCAH, use of the insanity defense and indemnity payment schedules on insurance policies dominating the discussions in the Indiana delegation's caucuses.

At the direction of the Indiana House, ISMA delegates introduced the resolution on drunk driving, which was adopted by the AMA House. The resolves read:

"Resolved, that the American Medical Association work toward promoting a reduction in deaths and injuries due to drunk driving by 50 percent during the next five years and by an additional 25 percent during the following five years; and be it further

"Resolved, that the AMA urge the citizens of the United Staets to work toward achieving such reductions in deaths and injuries due to drunk driving as a national goal."

Peter R. Petrich, M.D., who has been floor leader of the ISMA delegation for live years submitted his resignation from that post, Malcolm O. Scamahorn, M.D. was elected by his fellow delegates to fill this position for 1984,

#### Cost Controls

Concerning cost controls and DRGs, Margaret Heckler, secretary of the Department of Health and Human Services, said that the federal government is depending on physicians to protect patients from abuses that could occur under Medicare's new payment plan and other financing schemes aimed at cost control. If physicians don't accept that responsibility they may be forced into a "financing system so centralized that all payers

### Report of the AMA Delegation

join together in 'negotiating' with physicians, leaving you the options of objecting to the payment rules, going on strike, or leaving the country," she said.

Addressing the opening session of the House, Heckler warned that the American public would not tolerate current rates of inflation in health care, said she thought costs could be curbed without reducing quality, plugged the Reagan Administration's health care competition plans, and called for non-partisan discussion of Medicare's impending financial crisis.

The secretary acknowledged that Medicare's diagnosis-related groups (DRG) payment system would give hospitals "an incentive to increase admissions and to discharge patients early." She warned that the government would be watching for such behavior, and added that "we have a far better watchdog as we implement prospective payment—your integrity as physicians."

Because individual physicians make the final decisions under the DRG plan, she noted, "you can safeguard the quality of care."

#### **JCAH**

Because of the pressure to slow the increase in federal spending on medical care and rising numbers of limited-licensed health practitioners in competition for those dollars, the Joint Commission on the Accreditation of Hospitals (JCAH) has become the center of much controversy, emphasized by the following facts:

- State laws guarantee access to the hospital for limited-licensed health practitioners.
- Federal antitrust laws guarantee that state laws must be enforced.
- The combination of state licensing laws and federal antitrust laws guarantee that the JCAH must write limited-licensed practitioners into their medical staff bylaws or invite lawsuits.

The newly created Hospital Medical Staff Section argued that a medical staff means only physicians. AMA commissioners to the JCAH successfully argued that four years of study had convinced them that the best result is physician control of a hospital corral that includes non-physicians.

The JCAH was scheduled to vote on Dec. 10—four days after the AMA delegates voted—on a proposed draft of

hospital medical staff standards that would keep supervision of quality medical care under physician control by formally separating the composition of the medical staff, which would be controlled by fully licensed MDs and DOs, from the credentialing of clinical privileges, which also would be extended to limited licensed practitioners. This proposal, which would allow local solutions to a national problem, has been hammered out by the AMA over the past four years in a process that has included numerous revisions of the medical staff chapter of the JCAH Accreditation Manual for Hospitals, four field reviews, and consensus among many of the JCAH corporate members.

#### Insanity Defense

In an overwhelming vote the House called for a narrowing of the use of the insanity defense in criminal trials.

Despite objections from the American Psychiatric Association (APA) and the American Bar Association (ABA) that the AMA's proposal was too drastic, the AMA's governing body approved a 37-page report by the Board of Trustees' Committee on Medicolegal Affairs on the insanity defense in criminal trials.

The report calls for replacement of the conventional insanity defense with statutes that would permit a defendant to be acquitted on insanity grounds only if his or her mental disease prevented him from committing the criminal act with the requisite state of mind, or mens rea.

Currently, most jurisdictions use the more conventional definition of insanity, which permits criminal defendants to plead insanity and be acquitted by providing evidence that at the time of the crime, the defendant lacked the capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirement of the law.

The AMA is the first national organization to have adopted a policy calling for the narrowing of the insanity defense, said AMA President-elect Joseph F. Boyle, M.D.

#### **Indemnity Payment Schedules**

AMA delegates think indemnity payment schedules deserve further study but believe that continued physician freedom to establish their own fees carries with it the responsibility to refrain from billing

more than is reimbursed by an insurer or government program if this would bring financial hardship to the patient.

The delegates also "recognized the validity of a pluralistic approach" in the determination of third-party reimbursement for physicians' services. They stopped short, however, of a Council on Medical Service (CMS) recommendation that the AMA withdraw its advocacy of usual, reasonable, or customary charge profiles as the "preferential" method of determining reimbursement levels. Delegates also asked for a continued analysis of usual, customary, and reasonable (UCR) and indemnity payment determination methods followed by further recommendations at the Annual Meeting next June.

### Surrogate Motherhood

Surrogate motherhood was opposed by the AMA as delegates adopted a Judicial Council report enumerating grave ethical, legal, and psychological risks of a woman's being paid to bear a child for another.

"These arrangements do not appear to serve societal interests" and "do not provide a satisfactory reproductive alternative," Judicial Council Chairman Samuel R. Sherman, M.D., said in a report that was presented to the House of Delegates for information.

Dr. Sherman said that the Judicial Council was concerned about the problems that may arise when a woman agrees to become pregnant through artificial insemination for the purpose of relinquishing the newborn to the sperm donor and, usually, his infertile wife.

Furthermore, the report pointed out that physicians who participate in surrogate motherhood arrangements may be placing themselves in legal and ethical jeopardy.

#### **TEFRA Revisions**

Reimbursement, funding, and other financial issues highlighted a routine legislative agenda at the meeting.

Delegates urged repeal of the section of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 that could deny a fee for assistant surgeons at teaching hospitals. Concern was expressed that this provision, combined with the new Medicare prospective pricing system, might

### Report of the AMA Delegation

have an adverse effect on the availability of surgical residency positions.

The House called for competitive bidding under the contract care program in the Indian Health Service.

Prohibitions against special pay allowances for military physicians serving in managerial positions were opposed.

Provisions of the TEFRA law relating to utilization and quality of medical care should be extended to all non-military federal medical institutions, the House directed. Public funding for abortion services was reaffirmed.

In perhaps the most important issue it addressed, the House called for the reauthorization of the federal Higher Education Act to assure student access to adequate financing for medical education.

In non-reimbursement legislative matters, the House:

• Opposed a restudy of the AMA position opposing the establishment of a military draft of MDs that would discriminate against them by occupation.

• Opposed a federal role in decision making about the care of severely ill newborns. When hospitals are considering withholding life-sustaining treatment from severely ill newborns, the delegates said, the decision "should be based on the best interests of the patient and should be made at the hospital level, in consultation with multidisciplinary experts." The policy would prevent federal interference in medical decision making as exemplified by the "Baby Doe" case.

### Report of American Physicians Life

ACTION: Filed.

It has been approximately a year and a half since Indiana Physicians Life Insurance Company and PICO Life merged to form the new, stronger American Physicians Life Insurance Company.

During this past 18 months, APL has demonstrated continued growth in both product line and policyholder base. The company—owned by Physicians Investment Company which is controlled by physicians from Ohio, Indiana, Michigan and Kentucky—serves the physician and professional market with life, health and financial planning coverages throughout the company's marketing area.

As of year end 1983, APL reported life insurance in force at more than \$350 million with premiums received listed at \$7.6 million and an asset base of \$18.6 million. These figures represent an almost 20% increase over the previous year.

This strong market penetration into the physician and professional market demonstrates both the appropriateness and wisdom of your support of this merger between these two young insurance entities.

APL has introduced a number of in-

novative insurance coverages and made various product enhancements to its already comprehensive product line during this time period.

Lifestyle 3, a universal life plan introduced during 1984, offers an attractive interest earning alternative for individuals choosing higher levels of insurance protection over most similar type plans. Our Professional Disability Income and Office Overhead Expense plans have undergone extensive improvements to increase their protection element and competitiveness in the marketplace.

APL has established itself as a leader in the pension field with the introduction of Lifestyle 2 and the development of the defined benefit programs. The Pension Division of American Physicians Life provides pension-related assistance to physicians, including the development of individual or corporate plans, ongoing administration services and expert advice on your personal financial planning needs.

Indiana State Medical Association members additionally have the opportunity to receive high quality group insurance products through the various associationendorsed coverages underwritten by APL. These sponsored plans include lowcost group term life available on an individual or corporate basis, Group IRA and Hospital Confinement Protection.

APL's growth and progress is expected to continue during the balance of 1984 and throughout the upcoming year. The selective appointment of professional life insurance agents to represent the company and solicitous product development and improvement assure steady favorable growth for the company in the short and long term.

As a truly physician-owned and controlled life insurance company, Indiana physicians' interests are clearly being represented by the physicians-dominated board of directors comprised of physicians from Indiana as well as Ohio, Michigan and Kentucky. The following physician insurance professionals make up the board of directors for American Physicians Life: Arvine Popplewell, M.D., chairman; John E. Albers, M.D.; Carl Cooper, Jr., M.D.; Arthur B. Eisenbrey, M.D.; John J. Gaughan, M.D.; David A. Hull, M.D.; Thomas W. Morgan, M.D.; D. Brent Mulgrew, Esq.; Willian G. Olsen; David L. Rader; Benjamin H. Reed, M.D.; William E. Sovik, M.D.; Donald Chamberlain, M.D.-Arvine Popplewell, M.D., Chairman of the Board

### Report of the Physicians Insurance Company of Indiana

ACTION: Filed.

In PICI's continuing efforts to provide information to the physicians of the state of Indiana—of the progress of its company—I am pleased to provide the following report to the membership of the Indiana State Medical Association.

The 12 months preceding this report have been extremely gratifying as to the progress PICI has accomplished in penetrating the marketplace in Indiana. PICI has written nearly 600 Indiana physicians, which now represents 10% of the market share for the state. This is nearly twice the number of physicians we insured this time last year. In addition, the premium writings are up nearly two and a quarter times in the first six months of 1984 as compared to the same six months of 1983. (In the packets that have been provided to the delegates and attendees, a PICI interim report has been

included which shows the financial strength of your company.) The assets of the company have increased 30% since its inception in early 1982. This continues to be a positive growth rate.

As of June 30, 1984, we have set up in reserves for losses and loss adjustment, expenses both unpaid incurred and incurred but not reported, of \$624,311. Since inception, the company has received 38 professional liability claims. Five of these claims have been closed without any indemnity payment. Two claims were settled for a total indemnity payment of \$34,000.

In early 1983, PICI formulated and put into effect a full lines program of personal and commercial type policies developed for physicians. We are pleased with the growth in these areas. These policies are being sold through independent agents throughout Indiana. Your present agent may be included in this group, if you request it. In addition, the

company is in the process of developing a physicians' newsletter which will be disseminated to the ISMA membership on a quarterly basis. We hope to publish the first issue in the last quarter of 1984. It will be an informative letter and we hope you will take time to read it.

The goals and objectives of PICI as established by the Board of Directors are being attained and the credibility of the company is now firmly established. This could not have been accomplished in such a short time without the expertise and knowledge of our executive vice-president, Kurt Driscoll, his highly competent staff, and the physician members of the board and various committees who have so willingly contributed their time to help bring about the successful entry of PICI into the liability insurance field.

We look forward to a greater participation of physicians in the next 12 months.—Martin O'Neill, M.D., Chairman, Board of Directors

### Report of the Editor, Indiana Medicine

ACTION: Filed.

At the end of the third quarter of the fiscal year 1983-84, the actual income was about \$10,000 better than was expected and the expenditures were about \$12,000 below the budget figures. This financial cushion should persist throughout the fourth quarter.

Increases in income were due to substantial hikes in subscriptions for individuals not paying dues, local advertising, classified advertising, sale of reprints, subsidies for articles, CME subsidies, and a large increase in the size of the Physicians' Directory.

We have received an adequate supply of a wide ranging variety of articles on clinical and socio-economic subjects. Specialization in short articles and the subsidies received for articles which were necessarily longer than the customary two-page limit has made it possible to reduce the backlog of articles to less than six months. This, in turn, will allow planning for several new and unusual types of scientific writing in the future.

A readership study was performed on the February issue by David Labson, who is skillful and well respected in the assessment of medical publications.

Questionnaires were mailed to 500 chosen-at-random members of the Association. Those responding numbered 293, a very satisfactory 58.6%.

The responders who read each issue thoroughly added up to 65%. Those who read at least one issue in four were counted at 85%.

On a qualitative vote, 92% of the participants stated they wanted to continue receiving the magazine. On a scale of one to five, quality was rated at 3.5 and the need for publication at 3.3.

Why read Indiana Medicine? For clinical articles said 72%, for news—50%, for CME articles—48%, for editorial and commentary—75%.

"What's New?" was read by 88% and the medical history features received an okay from 80%.

Suggestions for improvement—many sincere and thoughtful suggestions were received. These will be considered by the Editorial Board and the Consulting Editors and will be adopted whenever possible.—Frank B. Ramsey, M.D., Editor

### **Report of Resident Medical Society**

ACTION: Filed.

During its first year of existence, the Resident Medical Society has represented the ideals and opinions of Indiana's resident physicians at the local, state and national level. In December, the RMS sent its first delegates to the AMA Resident Physician Section's interim meeting. In Los Angeles the delegation introduced a resolution on behalf of the Indiana RMS which pledged a commitment to reduce deaths and injuries due to drunk driving. This resolution was eventually passed by the AMA House of Delegates, after passage by the Resident Physician Section. Meanwhile, at the state level residents have been given the opportunity to discuss their concerns for the Indiana Peer Review Organization and proposed Indiana legislation in 1985 with speakers at monthly RMS Governing Council meetings. Issues of local concern within a training program or institution have also been addressed by the group.

In June, an experienced delegation attended the AMA-RPS annual meeting and successfully guided a controversial resolution calling for increased taxes on alcohol and tobacco designated for the Medicare fund through the Resident Physicians Section. This resolution was forwarded to the AMA for study. Again, the concerns of Indiana's residents were effectively represented in the national arena.

In addition to increasing the representation of Indiana residents, the Resident Medical Society has embarked on a major recruitment campaign for ISMA and RMS members, and has established communication links for organized medicine at every hospital in Indiana with a residency program. These communication links, known as key contact residents, have helped the RMS stay in close contact with the residents scattered among seven Indiana cities and meet the needs of residents at individual hospitals. In March, the RMS also started publishing a quarterly newsletter entitled RMS Vital Signs.

The Resident Medical Society has made an effort to provide educational programs for residents. Recent meetings have included discussion on borrowing money, stress, and organizing and financing the professional practice. These programs gave residents the opportunity to prepare themselves for their future in medicine and discover the action they can take during their residency to ease the transition into private practice.

Since members of the RMS vividly recalled the anxiety they experienced when they left medical school to begin their residency in Indiana, they decided their first large-scale service to residents would be to conduct an educational program and reception to welcome residents to the practice of medicine in Indiana. On June 27 a standing room only crowd demonstrated the need and desire of

residents and their spouses/significant others for more programs of this kind. Resource people and sponsors for the "Welcome" program have also indicated their enthusiasm for making it an annual event. Members of the "Welcome" committee are to be commended for their hard work and dedication which made the evening an overwhelming success.

The highlight of my year as RMS president was during the first interim meeting of the RMS on April 14. At the conclusion of the day's educational program and business sessions, Dr. Paul Siebenmorgen, chairman of the ISMA Board of Trustees, presented the RMS with the first component society charter issued by the Indiana State Medical Association. After striving for months to establish a firm foundation for residents today and in the future, our efforts as initial members of the Resident Medical Society were rewarded. The historic presentation denoted the vital role residents will play in the future of organized medicine and the importance of their involvement in the ISMA.

I believe the Resident Medical Society has made some remarkable accomplishments for an organization in its infancy and I am sure it will continue to make great strides in the future.—F. Steven Land, M.D., President

Commission Chairmen are listed on p. 1072

Medical Education ACTION: Filed.

The Commission on Medical Education met Nov. 20, 1983 and April 8, 1984. Dr. Shokri Radpour was named vice-chairman of the commission.

The major activity of the commission was that of the accreditation/reaccreditation process of hospitals and organizations for CME. During the year there were eight hospitals reaccredited for continuing medical education and 10 organizations reaccredited. One organization was granted its initial accreditation. One organization was denied accreditation and two organizations had their accreditation deferred for the need of additional information. In total there were 22 accreditation actions during the year.

The commission conducted its second annual Site Surveyors Workshop Nov. 19, 1983. The workshop included the study of the new ACCME Essentials for Continuing Medical Education with Guidelines and the suggested Pre-survey/ Survey document. Recommendations for changes were then made to the Commission on Medical Education.

The commission reviewed the Essentials, Guidelines, and the Pre-survey forms with the recommendations from the workshop and approved a corrected Essentials and Pre-survey form for ISMA use. The commission also reviewed the Protocol for Review and Recognition of State Medical Associations for use by the ACCME.

The commission reviewed recommendations to be made to the ACCME relative to the accreditation for intra-state CME offerings in order to eliminate the confusion relative to intra/inter state CME program accreditation. The recommendations were then forwarded to the ACCME for their consideration.

The commission nominated Dr. Eugene Gillum, chairman of the Subcommission on Accreditation, and Dr. Franklin A. Bryan, chairman of the Commission on Medical Education, as ACCME site visitors. The commission also nominated Dr. Franklin A. Bryan to be a member of the Committee on Review

and Recognition (CRR) of State Medical Associations of the ACCME.

Dr. Bryan was invited to attend the ACCME meeting in Chicago on June 7, 1984 as a guest. Dr. Bryan spoke regarding intra/inter state CME problems with recommended solutions to be presented at its next (ACCME) meeting. At the same meeting of the ACCME, Dr. Bryan was appointed as a member of the new Committee for Review and Recognition (CRR) of State Medical Associations. At the organizational meeting of this committee, he was selected for a three-year appointment.

The Subcommission on Accreditation met on the same dates as the commission just prior to the commission meetings. The chairman of this commission is Dr. Eugene Gillum, the vice-chairman, Dr. Kelley Chambers. The subcommission reviewed all of the accreditation/reaccreditation documents and made recommendations to the commission. The subcommission also reviewed the recommendations from the workshop relative to the new Essentials and Guidelines and the Pre-survey/Survey forms making recommendations to the commission on these documents also.

The chairman of the Commission on Medical Education wishes to acknowledge and express his appreciation for the activities of the subcommission, and thanks Dr. Gillum, Dr. Chambers, vicechairman, and members for their input into the continuing medical education activities of the ISMA. The chairman also wishes to acknowledge and express his appreciation for the activities of Dr. Radpour, the vice-chairman, and the members of the commission for their activity in CME accreditation for the ISMA. The site visitors are also recognized for their outstanding activity, without which the accreditation process could not be carried out.

Finally, the outstanding work and dedication of the ISMA staff member, Beckett J. Shady-King, without whom the subcommission and commission could not have functioned effectively, is recognized. The chairman for the commission wishes to express his deep apprecation.—Franklin A. Bryan, M.D., Chairman

## Legislation ACTION: Filed.

Your Commission on Legislation has been quite active throughout the past year. The activity seems to always pick up pace when the Legislature is in session. All the bills that had an impact upon the medical profession were discussed at length at a number of commission meetings during the winter and spring.

As your chairman, I spent a great deal of time at the Legislature. I had an opportunity to testify at the Generic Substitution Reference Committee on the House side. Through the efforts of your legislative lobby, Rick King and myself, a Generic Substitution Bill did evolve that contained all of the major provisions that the commission members felt were important for protection of the patient, the physician, and the pharmaceutical industry.

The Commission on Legislation was involved with the leadership of ISMA by impacting upon a bill that would have eliminated a physician from being commissioner of the State Board of Health. Final provisions of the bill did provide for the governor to appoint the commissioner, but the commissioner must be a licensed physician.

Numerous other bills were followed and lobbied throughout the legislative session. Licensing of athletic trainers, physical therapists, and other paramedical personnel were followed quite closely. Testimony was presented on numerous occasions representing ISMA's position.

Another exciting event has occurred and is continuing to evolve this year. The Commission on Legislation has met jointly with the IMPAC board. A very comprehensive program is being established for the fall of 1984. We have established the goal of visiting every county medical society from September through December in carrying the message for not only the Commission on Legislation, but the IMPAC board. It is our goal to have a commission member and an IMPAC board member at every county meeting. We recognize that this is quite ambitious, and we may fall short of our goal, but felt that it was important to set our standards high. We will

continue to maintain liaison with the IMPAC board.—Edward L. Langston, M.D., Chairman

### **Sports Medicine**

ACTION: Filed; referred to Board of Trustees with recommendation that the ISMA recommend to the Dept. of Public Instruction that state-certified trainers be provided for all Indiana secondary schools.

I am pleased to report that the ISMA Commission on Sports Medicine continues to progress and, in 1984, we have made a significant impact upon the medical care of Indiana's athletes.

The following summarizes the major highlights, listed in the order of their significance:

- 1. Elevation of the commission from an ad hoc organization to a standing commission.
- 2. A definitive statement defining the purpose of our commission, to be included in the ISMA bylaws.
- 3. During the fall football heat crisis of August 1983, the commission held emergency meetings and passed a set of guidelines to reduce further heat-related illnesses. The 1HSAA instituted our recommendations with a reduction in incidents. Furthermore, we were able to help by recommending moving back the start of fall football in order to avoid the heat/humidity problems. By 1987, we hope to have football moved back to after September 1st, to avoid heat stress.
- 4. A panel of head and neck specialists recommended guidelines for the prevention and treatment of head and neck injuries. These suggested guidelines were distributed to team physicians, trainers and coaches
- 5. Our recommendations to the IHSAA to discontinue the two-a-day basketball tournament format was presented to the IHSAA governing board and they have elected to change the regionals and sectionals to a Friday-Saturday format, but not the semi-finals or the state finals.
- 6. Our commission has *strongly* recommended implementing a plan to place a trainer in every high school by 1990. We propose setting up a postgraduate summer program for a designated

teacher in each high school to educate this individual on training techniques. These teacher-athletic trainers (TATs) would be eligible after three summers' education. to be certified as trainers and would be most beneficial in caring for Indiana's athletes. We propose that this be done through the Department of Public Instruction; however, we have not yet persuaded Dr. Negley of the impact that this would have in improving the "working" conditions of our athletes. We will be focusing our direction to proposing legislation to set up this teaching program. This is the most important advancement the ISMA Commission on Sports Medicine could undertake-that of providing each and every athlete the opportunity to work with such an individual in preventing injuries and medical complications.

7. The commission, under Dr. Phil Eskew's leadership, has revised the IHSAA Physical Form to update the contraindications to exercise and also to streamline the forms. Furthermore, the commission reiterated the position that IHSAA Physical Exams be performed by physicians practicing in Indiana with an unlimited license to practice medicine.

In summary, the ISMA Commission on Sports Medicine is progressing toward our goal—that of improving the medical care of our Indiana athletes and related personnel.

We feel a great advancement in the future of sports medicine in Indiana would be the inclusion of trainers in each participating high school. Then, we would feel we have reached the goal we set out to accomplish two years ago.

It has been a great honor to have served as chairman these past two years. I will look forward to helping the next chairman advance these goals.—Gary L. Prah, M.D., Chairman

# **Public Relations ACTION:** Filed.

The past year has seen some exceptional developments in ISMA's external public relations.

Heartbeat, the 13-segment series of half-hour television programs sponsored by the Association, was aired on 27 stations throughout the nation, including Public Broadcasting System affiliates

from Florida to Alaska and Puerto Rico to Pennsylvania. Last spring, *Heartbeat* was honored by the International Association of Business Communicators with a first-place award in the Bronze Quill Awards Contest. The award is given for the best communications series and *Heartbeat* received top honors in the largest contest with the most entrants in the history of the competition.

Through the Commission on Public Relations, ISMA is taking an assertive, innovative step in shaping public attitudes toward physicians. While surveys demonstrate that patients admire and are satisfied with their personal physicians, the public attitude toward physicians in general is not so positive and there is evidence that negative attitudes and dissatisfaction are increasing. Because negative public attitudes create a climate which facilitates the development of such programs as prospective pricing, DRGs, mandatory assignment, and so on, the Commission on Public Relations has taken steps to change those attitudes. With approval and funding through the Board of Trustees, the commission has contracted with Holden & Co., a public relations and marketing firm specializing in the health care field, to launch a statewide public information and education campaign. Radio and newspapers advertisements and billboards are being utilized throughout the state to carry out the goal of the program—positioning the physician as the patient's advocate. All materials produced by Holden & Co. for the campaign are reviewed by a specially designated subcommittee of commission members.

Ongoing public relations programs such as *Your Hoosier Doctor Says*, the ISMA health tips column used by newspapers throughout Indiana, continue to be successful components of our community relations. The commission and PR staff have also been the liaison for involvement with organizations such as the American Lung Association, American Cancer Society and the Indiana Academy of Family Physicians.

Internal communications—ISMA Reports and Siebenmorgen's Notes—continue to keep the membership informed of events of interest both within and outside of the Association.

Once again, ISMA, through the recom-

mendation of the Commission on Public Relations, contributed \$100 to the National Journalism Center to help train responsible journalists.

Finally, the commission selected award winners among print and broadcast entries in the annual Journalism Awards competition as well as selecting a physician to be honored with the Physician Community Service Award.

1'd like to express my deep appreciation for the outstanding cooperation and efforts of each member of the Commission on Public Relations and the ISMA PR staff during the past year.—John V. Osborne, M.D., Chairman

# Subcommission on Insurance ACTION: Filed.

Members of the Subcommission on Insurance met on Jan. 11, 1984 to negotiate the new health and dental insurance contract for ISMA members and their employees, to review the in-depth claim data provided by The Lincoln, make recommended changes to the program which could have a beneficial impact on premium stabilization and increase benefits to the participants, and to handle other insurance-related matters.

Although it is still too early to be optimistic about the changes approved by the Board of Trustees and incorporated in the 1984-85 health insurance program—insofar as premium stabilization is concerned—the monthly claim expense report for April, May and June show that we have been below our monthly dollar cap allotted to pay claims; and that is a good sign.

After careful review of all the data provided by The Lincoln, the subcommission recommended, and the Board approved, a six-month rate renewal which included a 33% increase for Plan 1, 14% increase for Plan 2, and a 25% increase for Plan 3. A new Plan 4 comprehensive major medical with a \$2,000 deductible (three per family), and 80% coinsurance to \$10,000 (\$30,000 maximum per family) per year was also approved. Plan 4 rates were set at 24% less than Plan 2 rates.

The reason for the six-month renewal was the Board approved going to age-banded rates starting Oct. 1, 1984. The subcommission was to review all the data

and negotiate the new age-banded rates on July 25, 1984. It is anticipated, because of the current claim experience, that the rates will be the same as those approved in January 1984.

Other actions taken by the subcommission, and approved by the Board, aimed at stabilizing future premium increases were: change the pre-existing limitation to read maximum \$1,000 benefit until 90 days without care or treatment or 24 months continuously insured for all new participants in the health insurance program; change the eligibility requirement for future participants to read, medical evidence of insurability required on all individuals and all groups with less than six lives: and that medical evidence of insurability be required of any individual or group with less than six lives who shift to a more liberal plan.

In addition, the Board approved modifying the mental and nervous benefit to read 42 days maximum hospital confinement per year, 92 professional visits per year (42 in-hospital and 50 out-patient), \$6,000 maximum payment per year for professional fees, include day/night care plus residential treatment services, and continue \$50,000 lifetime maximum for professional fees only; and change Plan 2 and Plan 3 benefits to include 100% payment for preadmission testing with no deductible, and 100% payment for outpatient surgery, no deductible, on a list of procedures approved by ISMA.

The Board also approved extending the health and dental coverage to the surviving spouse of a non-covered member with evidence of insurability, and approved extending coverage for disabled and retired employees of ISMA members. The extension of benefit for disabled employees is: less than one year employment, two months extension; one to two years employment, one year extension; and more than two years employment, two years extension. The extension of benefit for retired employees is: age 55 with 15 years of service, extended benefits to include Medicare supplement.

The subcommission reviewed Resolution 83-25, Disability Insurance Form, at the Board's request, and agreed that a disability form regarding total and permanent disability should provide more work-related information for the attending physician to answer the question ap-

propriately. Therefore, the subcommission recommended, and the Board agreed, that the resolution should be sent to the Health Insurance Association of America (H1AA) and to the ISMA Business/Medicine Coalition asking for their recommendations on how this could be accomplished. HIAA sent back a current copy of its disability form requesting ISMA's opinion as to whether or not it contained enough work-related information to satisfy ISMA's resolution. After reviewing the form, the subcommission sent H1AA a copy of the form it received from the Fort Wayne/Allen County Business/Medicine Coalition suggesting that it would make a good companion piece or addition to the HIAA form. HIAA has put the issue of modifying its standard claim form to reflect an employer evaluation of other jobs an individual might be eligible for in the company on the agenda for its next committee meeting.

Resolution 83-33, Medical Protective Company (Denial of renewal of liability insurance coverage) was also given to the subcommission for action by the Board. After reviewing the resolution the subcommission recommended, and the Board approved, sending a letter to the Indiana Insurance Commissioner requesting his opinion as to whether or not denial of renewal of liability insurance coverage without giving a reason is a violation of any law, rule or regulation. The response from the Insurance Commissioner's office was that a non-admitted or admitted insurer writing professional liability coverages in this state may refuse to renew a policy without giving prior notice or reason unless the contractual terms of the policy that they have previously issued state otherwise.

In addition to negotiating the new agebanded rates on July 25, the members of the Subcommission on Insurance will respond to The Lincoln's request for clarification of the new mental and nervous lifetime maximum; review Lincoln language on organ transplants for possible inclusion in the ISMA master contract; and review the Ontario Medical Association long-term disability insurance plan for possible recommendation to, and duplication by American Physicians Life for ISMA members.

The subcommission will always be

responsive to the members' needs and will continue to search the marketplace for the best programs available to meet those needs.

I want to thank the subcommission members who gave generously of their time and efforts and the ISMA staff for their excellent assistance.—John Mac-Dougall, M.D., Chairman

Subcommission members:

Garry Bolinger, M.D. William Cutshall, M.D. John Lanman, M.D. Francis Price, Jr., M.D. Dwight Schuster, M.D. John Thomas, M.D.

### Physician Impairment

ACTION: Filed.

The Commission on Physician Impairment matured in 1983/84, primarily in the clarification of our role in Indiana medicine and in expansion of the numbers of Indiana physicians knowledgeable about the general identification and management of impaired colleagues.

The commission was very much involved in the formulation of a second effort at rewriting Medical Licensing Board regulations. Fortunately, the new regulations which were signed into law by the Governor in April 1984 create a "diversionary path." An Indiana physician suffering impairment from drugs, psychiatric difficulties, senility, etc., may seek out and volunteer to cooperate with a duly authorized impaired physician committee at the local hospital, county society, or ISMA level, and as long as he is cooperating fully with the directives of the impaired physician group, he is immune from reporting to the Medical Licensing Board. This major change creates the positive situation wherein an impaired physician and/or hospital or colleagues find involvement with the impaired physician process to be preferable to other alternatives of management of such impairment.

In March 1984, the first Indiana Impaired Physician Commission-sponsored training seminar was conducted, with three national speakers including Dr. William Rial, immediate past president

of the AMA, and an attendance of over 100 members of the ISMA. The nature of physician impairment, its identification and management, as well as small group training in confrontation techniques, made the day very successful from the perspective of the attendees. In the process, the awareness of Indiana physicians of both impairment and its management seems to have significantly increased.

The commission is currently working on a new effort at confidential but effective record keeping of impaired physicians, in part to prevent "geographic cures" of impaired physicians moving from one location to another, and to allow more thorough and beneficial follow-up to impaired colleagues.

Overall, the activities of the commission seem to be steadily increasing, with consistently greater numbers of physicians with problems coming to our attention. As is so often the case with this kind of enterprise, our overall observations are that work has just begun.—Larry M. Davis, M.D., Chairman

#### Medical Services

ACTION: Filed.

The business of the ISMA Commission on Medical Services involves acting on actions mandated by the ISMA House of Delegates as well as interim issues referred by the ISMA Board of Trustees.

During fiscal year 1983-1984, the Commission met and acted on Resolution 83-1 (Foot Surgery) referred by the ISMA House of Delegates. The Commission noted that the Federal Trade Commission has placed constraints on professional associations. The Commission is therefore acting on this issue in a very deliberate fashion. At the present time, the Commission is meeting with ISMA legal counsel in an attempt to assure quality of care while at the same time avoiding any semblance of being in restraint of trade.

The Commission is also currently involved in studying the concept of ISMA establishing a fee review council to assist county medical societies in local fee review. Since this is another legally sen-

sitive issue, the Commission is working closely with ISMA legal counsel in an attempt to develop a legal mechanism for conducting voluntary fee review. Once these issues have been resolved, appropriate recommendations will be made to the ISMA Board of Trustees and/or House of Delegates.—John D. MacDougall, M.D., Chairman

### Constitution & Bylaws

ACTION: Filed.

The Commission on Constitution and Bylaws has met twice thus far in 1984. During these meetings the commission incorporated all bylaw amendments mandated by the 1983 House of Delegates into our current document. Again, our commission has been privileged to have total participation from its membership in a most active and efficient manner.

The Commission reviewed the Constitution and Bylaws of the Intern and Medical Resident Society and made recommendations to the Society regarding clarification of same.

The Commission is submitting resolutions calling for modifications that will assist ISMA commissions and committees in their activities. Please give the resolutions consideration and be assured that your Commission is diligently striving to fulfill its responsibilities as charged in the bylaws.

I wish to acknowledge the dedicated efforts of Ms. Beckett Shady-King and Ron Dyer, ISMA staff, without whose assistance our task would be hopeless.—Lloyd Hill, M.D., Chairman

### **Reports of Committees**

Committee Chairmen are listed on p. 1072

### **Future Planning**

ACTION: Filed.

I would like to express my appreciation to the members of my committee for their excellent attendance, along with support of staff which has been quite helpful and informative. I would like to thank Dr. Lukemeyer for challenging our committee in a number of important areas involving medicine today.

The Future Planning Committee has been involved in several areas. One has been the assessment of future practice environment. We have spent time discussing such areas as the New Jersey DRG experience and the number and distribution of physicians at present and in the future.

We spent considerable time evaluating the different staff responsibilities and the ISMA budget. After considerable evaluation, it was felt that certain staff changes would be indicated and job descriptions somewhat changed. The first area is that of the field representative and his job description. It is our feeling that field representatives are somewhat overburdened with a number of areas, that their duties should be more specifically defined and that this should be especially devoid of time-consuming legislative activity. We recommend that the field representatives be involved more with the local districts and counties, with their organization and operation, and with disseminating information to these local groups, as we feel communication is the most important area. Because the state, at times, does poorly communicate to its members, we feel that field staff activity involved in this area is quite important. Thus, we will maintain our two field representatives. but their involvement will be more in the local societies.

We also looked at the need for expanding our legislative staff, as we feel that legislation over the next one to two decades is going to be extremely important and many laws will be put into effect involving the practice of medicine. We feel that we should be involved in preventing many of these laws that will be not only adverse to physicians, but

adverse to our patients. Thus, we recommended that additional legislative staff be added. This was supported and two additional members will be involved in legislation drafting, etc.

It was also felt that much of what physicians do is not always imparted to our patients. We feel that further strengthening of our public relations staff is important so we have recommended the employment of an additional staff member.

We were also asked to evaluate the dues structure. It became quite obvious that a dues increase is necessary, as the expenses of operating the organization have increased considerably over the last eight to nine years and there has been no dues increase since 1975. The need for a dues increase was evaluated in detail and recommendations were made to the Board to have a dues increase in the next year to help improve our deficit budget.

As far as future involvement for the committee, we have two areas in particular that we will be addressing. One will be the district meetings and their success. It has been noted in the last four to five years that attendance at district meetings has been down and, in many instances, that most of the physicians in attendance are officers from the Indiana State Medical Association. A smaller number are the local physicians. The Future Planning Committee will study the structure of the district meetings and make recommendations to the Board as to whether they be continued in the same pattern, or if necessary changes need to be made to improve the effectiveness of these meetings.

The committee also has been studying future office space options; a subcommittee has been appointed and is currently studying this particular problem. Office space has been in the process of being evaluated for the last eight to I0 years and, up to this date, no concrete recommendation can be made to the Board. We hope that our committee will have some type of recommendation by the end of this year for future space options.

Again, I would like to express my appreciation to the committee and staff for their support thus far for the Future Planning Committee.—William C. VanNess II, M.D., Chairman

### Grievance

ACTION: Filed.

The Grievance Committee met during 1984 and reviewed approximately 10 cases, several of which are still pending.

As usual, the lack of good patient communication has been the source of most of the complaints that the committee has received. As chairman, I wish to thank the two other members of the committee for their attendance and valuable assistance during the year.—G. Beach Gattman, M.D., Chairman

### Medical Education Fund

ACTION: Filed.

Representatives from the Trust Department of the American Fletcher National Bank, Mr. Fran Brezette and Mr. Larry Cole, met with the Indiana Medical Education Fund Committee in May 1984. A review of the portfolio's performance was presented. It was estimated that the portfolio could double in value within six years, assuming 12% interest and excluding contributions and distributions.

The AMA-ERF provided \$74,375.89 for the Indiana University School of Medicine in 1984. Prior contributions have been: 1983—\$66,489.88, 1982—\$59,372.97, 1981—\$55,556.83, 1980—\$48,476.18.

Distributions made to the Indiana University School of Medicine for 1983 and 1984 provided funding for the Research Scholars program and the Research Fellowship program.

The committee again wishes to acknowledge the fine work of the Auxiliary in raising money for this fund.

Fund Balance: 7-1-83	\$534,110.30
1983 Distribution to Indiana	
University School of Medicine	(-60,000.00)
1984 Distribution to Indiana	
University School of Medicine	(-60,000.00)
AMA-ERF Contribution	74,375.89
James A. Harshman, M.D.	
Memorial Fund	2,245.00
Trustee Fees	(-2,000.51)
Interest Income	39,274.16
Net Realized Gains	44.19
Fund Balance: 6-30-84	\$528,049.03
-John W. Beeler, M.D.,	Chairman

### Reports of Committees

### Reduce Drunk Driving

ACTION: Filed.

Resolution 83-3, passed by the 1983 House of Delegates, created an ISMA Reduce Drunk Driving Committee. The established goal of the committee is to reduce deaths and injuries due to drunk driving by 50% during the next five years and by an additional 25% during the following five years. The committee was recognized for its efforts in working toward this goal in the Dec. 2, 1983 issue of the *American Medical News*.

The committee has worked closely with the Governor's Task Force to Reduce Drunk Driving in accomplishing this goal. Mr. Stephen Goldsmith, chairman of the Task Force, recently stated, "I think the teamwork between the Medical Association and law enforcement authorities has been, in part, directly responsible for the reduced number of deaths and injuries from drunk drivers."

The Reduce Drunk Driving Committee currently is diligently seeking funding in order to wage a statewide television blitz against drunk driving. It is planned that these commercials will be aimed at all ages of drivers. Additionally, the chairman of the committee participated with Governor Robert Orr and Senator Dan Quayle in the Hoosiers Against Drunk Driving Conference held in Indianapolis, Aug. 31-Sept. I, 1984. According to Governor Orr, "HADD will launch a model statewide thrust for high school students and adults who wish to prevent drunk driving and we believe it will be the first effort of this kind held in the nation."

I wish to express my appreciation to the many individuals who have contributed their expertise in addition to the dedication of the committee members in an effort to accomplish our goal.— Michael B. DuBois, M.D., Chairman

### Ad Hoc Malpractice Advisory Committee

ACTION: Filed.

The Ad Hoc Advisory Malpractice Committee met on several occasions during 1984 and monitored closely the legislative efforts during the 1984 session of the Indiana State Legislature.

Meetings with the Insurance Commissioner of the State of Indiana and both defense and plaintiff attorneys have confirmed the fact that the Patients Compensation Fund established under the Malpractice Act has been invaded for sums of money to pay claims to an extent which had not been anticipated. This has seriously jeopardized the integrity of the Patients Compensation Fund and necessitated a 50% surcharge on malpractice premiums to prevent the fund from becoming financially insolvent.

Various methods have been discussed to protect the essential features of the Malpractice Act and the fiscal responsibility of the Patients Compensation Fund. Ongoing conferences with the insurance industry, the Insurance Commissioner, the legal profession and the medical profession will hopefully lead to a consensus about what actions can be taken to retain the necessary features of the Malpractice Act. Such recommendations will be passed on to the president and Board of the Indiana State Medical Association for their consideration and action. If adopted by the ISMA as official policies, these views will be presented to the Legislative Commission established by the last legislature.—J. William Wright Jr., M.D., Chairman

### Ad Hoc Committee on Student Representation in the House of Delegates

ACTION: Filed.

In 1983, the convention charged that a recommendation be made in 1984 regarding student representation (number of delegates) in the ISMA House of Delegates. A committee representing the ISMA leadership, students and various geographical locales of Indiana was named by the ISMA president, Dr. George Lukemeyer. In initial committee meetings, it became readily apparent that a more crucial issue existed than even student representation with the House of Delegates—that being lack of a formally organized student constituency group. In this regard, the committee, through aid

of the ISMA staff, reviewed organizational charters and numerical representation of student societies in other state associations. The ad hoc ISMA committee met with ISMA student representatives and student government representatives in this regard on several occasions.

Currently, the medical student government and the ISMA student representatives have formed a task force to formally establish an ISMA student organization which will be representative of all student 1SMA members. Technical assistance and advisory consultation will be provided by the ISMA staff and the ad hoc committee. The student task force recommendation will be reviewed by the Indiana University School of Medicine student government and presented to the ad hoc ISMA committee this fall. At that time, the ad hoc committee will analyze all material presented and make its final recommendations to the House.-William H. Beeson, M.D., Chairman

# Ad Hoc Geriatrics

ACTION: Filed.

The ad hoc Geriatrics Committee, appointed in February 1984, met once so far in 1984 to discuss medical care for the aged and how to establish better communications with senior citizens.

Resolution 83-31, Physician Patient Visits at Nursing Homes Conflicting with Inspection Protocol at the State Board of Health, Medicare, and Medicaid Inspection Teams; Resolution 83-35, Alternatives to Nursing Home Care; and Resolution 83-36, State Board of Health Regulations on Nursing Homes; were reviewed by the ad hoc Geriatrics Committee at the Board of Trustees' request.

After reviewing Resolution 83-31, it was pointed out that the Indiana State Board of Health is not in a position, nor does it have the authority, to make changes in the certification process as called for by this resolution. Therefore, the ad hoc committee sees no resolution to this problem at this time, and hopes the study by the Institute of Medicine will give some insight and guidance to this area of conflict between state and federal regulations.

### **Reports of Committees**

The committee reported to the Board of Trustees that it felt the Department of Public Welfare action requiring preadmission screening for patients entering nursing homes to determine if such placement was medically necessary satisfied the major concern of Resolution 83-35. However, the committee has some special concerns about the quality and cost effectiveness of home health care and fears that the public may bear the burden of this expense. They also fear that the Diagnosis Related Groups (DRGs), which limit the patient's time in the hospital, will eventually work their way into the nursing homes and result in premature movement of patients out of nursing homes and into home health care or custodial care. The committee feels that the first priority of any determination of need program should go to existing agencies supplying home health care service.

The committee agreed with the intent of Resolution 83-36, presented to the ISMA House of Delegates by the DeKalb County Medical Society, but noted the law regarding sanctions and fines is not subject to change by rule or regulation of the Health Facilities Council. The committee believes the new regulations will respond to this resolution, but sent a copy to the DeKalb County Medical Society for their review and comments.

Report D of the AMA Board of Trustees, Health Care for an Aged Population, was discussed, along with the need for better communications with senior citizens. The committee recommended that the ISMA president send a letter to the county medical society presidents asking them to designate one or two physician members from their society who would be willing to meet with senior citizen groups in their area to discuss such

topics as cost of medical care, rationing of medical care, DRGs, and other medical related topics.

In addition, the committee is setting up a meeting with Maurice Endwright, president of the Indiana Federation of Older Hoosiers, and other key contacts from this group to discuss and exchange ideas related to geriatrics and the above topics.

I wish to thank members of the ad hoc Geriatrics Committee for taking their time to review these issues.—Bill L. Martz, M.D., Chairman

### Negotiations

ACTION: None.

No meetings were held. No business was referred to the committee.—Herbert C. Khalouf, M.D., Chairman

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### Scientific Exhibit Winners

### The 'Peculiar Features and Mysterious Nature' of Duchenne's Muscular Dystrophy

Exhibitor: Charles A. Bonsett, M.D., 6133 East 54th Place, Indianapolis, Indiana 46266.

Attendants: Charles A. Bonsett, M.D.

Description: This exhibit is a synopsis presentation of a continuing long-term clinic-laboratory research program, involving the Riley Hospital Muscular Dystrophy Clinic, the Indiana Neuromuscular Research Laboratory at Central State Hospital, and more recently, Community Hospital of Indianapolis.

The approach is original. It utilizes the clinical manifestations of Duchenne's muscular dystrophy as an avenue to gain insight into the chemical nature of the disease.

The study commences in the clinic, and by further evaluation in the laboratory of questions prompted by clinical observation, proceeds logically to a site of



First Place Winner

significant metabolic dysfunction at the molecular level.

The abnormality is correctable in the laboratory. Is it correctable in the clinic?

The FDA has given consent for a limited clinical trial of the naturally-occurring correcting metabolite with five volunteer Duchenne muscular dystrophy patients (IND 17, 848). Now in its third

year, the trial is conducted with appropriate informed consent and institutional review committee monitoring procedures.

The exhibit presents the experience to date with these patients, and outlines the research method and logic which utilizes the "peculiar features" of the disease to gain an insight into the "mysterious nature" of its cause.

# Direct Determination of Muscle Strength, Speed and Endurance

Exhibitor: Larry K. Steinrauf, Ph.D., IU School of Medicine, 635 Barnhill Drive, Indianapolis, Indiana 46223.

Attendants: Larry K. Steinrauf, Ph.D. and Arthur Schulz

Description: Strength, speed, and endurance of skeletal muscle depend ultimately on the biochemistry and physiology of the muscel fibers involved. Fast twitch and slow twitch muscle fibers are very different in their strength, speed of contraction, ability to perform high-speed work, ability to perform low-speed work, and utilization of energy sources. Muscel testing is useful to follow the extent and course of disease or injury, and to follow the progress of rehabilitation or of athletic conditioning. Muscle testing is often an alternative to muscle biopsy.

I. We have combined the Cybex muscle testing instrument with an Apple computer for the accurate and rapid determination of strength and endurance at various speeds.



Second Place Winner

2. From the rate of carbon dioxide production during and following stress testing (using the same muscle systems) we can calculate the extent and rate of use of each of the energy sources: high energy phosphate, lactic acid production,

and substrate oxidation.

Thus by noninvasive methods we can obtain the important biochemical and physiological parameters of a muscle system.

### Scientific Exhibit Winners

### The Effect of Alcohol on the Skeletal System

Exhibitor: Raymond O. Pierce, Jr. Attendants: Raymond O. Pierce, Jr. Description: Alcohol causes a variety of lesions of the musculoskeletal system. Heretofore, these lesions have been commented upon individually but very few attempts have been made to present the composite picture. These changes will be divided into the following categories:

Osteopenia—It has been found in a study of postmortem speciments that bone samples in young alcoholics were similar in bone mass to people of a uch older age group. All alcoholics in this study were under 45 years of age but they have bone density the same as non-alcoholic men and women over the age of 70. This decreasing bone mass appeared to cause an increase in fractures in these individuals.

Osteonecrosis—Osteonecrosis has many causes and can occur at many anatomical sites. However, one of the most common sites is the hip joint. In a review of 111 hips at the Indiana University Medical Center, alcoholism was one of the leading causes of osteonecrosis of the hip in young adults.

SUGGESTED TREATMENT—A strong index of suspicion is needed to make an early diagnosis of osteonecrosis. The earlier the diagnosis is made and the treatment initiated, the better the results. There is a tendency for most of these lesions to progress until the hip is destroyed. The aim of treatment should be



Third Place Winner

to prevent this from occurring.

In a recent review of the prognosis of osteonecrosis of the hip at the Indiana University Medical Center, we found that the alcoholic had a poor prognosis. This was due to the fact that these cases were frequently bilateral and usually a delay was made in making the diagnosis and starting the appropriate treatment.

Osteopathy—Chronic alcoholism may be the greatest cause of peripheral neuropathy in the United States. One of the complications of any peripheral neuropathy can be joint changes. This disturbance of the joints is commonly referred to as a neurotrophic or Charcot joints.

SIGNS AND SYMPTOMS—The true incidence of these lesions are not known. It probably occurs more than it is being reported. The criterion for this diagnosis is distal muscle weakness, absent ankle jerks, and decreased cutaneous vibratory and position sense. A number of these patients also exhibited severe soft tissue changes in the legs and feet such as chronic edema, ulceration, and increased pigmentation in addition to bony deformities of the feet.

### Debby Knox Television (Single Story)

This year's winner of the television (single story) award is Debby Knox, "Health Scene" reporter/producer, WISH-TV, Channel 8, Indianapolis.

Her winning entry was "The Benefit of Aerobic Exercise," a study of how aerobic exercise can strengthen the heart muscle significantly if performed correctly. In her report, a computer graphic showed how the muscle works during strenuous exercise.

Debby, a native of Michigan and a graduate of the University of Michigan, joined WISH-TV four years ago. Prevjously, she worked at radio and television stations in Elkhart and South Bend, and in Ann Arbor, Mich.

In addition to the ISMA award, Debby won the 1984 Hoosier Heartbeat Award for reporting on a press conference held by various medical associations, criticizing advertising policies of the tobacco industry.

### Carrie Jackson Television (Series)

"The Cancer Nobody Talks About" is the title of the award-winning television series by Carrie Jackson, co-anchor and health specialist for WTHR, Channel 13, Indianapolis.

The two-week series, dealing with the detection of colorectal cancer, also received the 1984 Casper Award. The series, shown as part of a mass screening project throughout central Indiana-a project that offered free tests to detect occult blood in the stool—prompted 73,000 people to pick up self-help test kits. (Of the nearly 26,000 kits returned, 844 had positive results and 40 were diagnosed as having colon cancer.)

Before joining WTHR last year, Carrie worked as a news anchor for WJAR-TV in Providence, R.I., which won the 1983 Edward R. Murrow Regional Award for News Excellence. She also received the 1982 American Cancer Society Broadcaster of the Year Award for health and medical reporting, and was named Top Female Reporter in a 1982 Providence poll.

Originally from Texas, Carrie is a graduate of Wayne State University.





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### Tim Johnson Radio

Tim Johnson, assistant news director of WTLC radio, Indianapolis, received his third ISMA journalism award, having won in 1981 for his radio series on juvenile alcoholics and the next year for his follow-up series.

Tim's 1984 award was for a five-part cancer series identifying environmental and socio-economic conditions that could influence the incidence of cancer. The study revealed, for reasons yet unknown, that certain cancers disproportionately strike blacks and that, as a group, blacks are less informed than non-blacks of the warning signs and the dangers of cancer.

The medical field is not new to Tim, who spent several years as a medical technician certified by the National Registry and the State Emergency Medical Services Commission.

Tim, a native of Indianapolis, has received two Casper Awards, and AP and UP1 awards for his reporting.

### Curt Brown Print (Single Story)

The winner of the newspaper (single story) award is Curt Brown, editor and publisher of the Tri-County News, a weekly published in Washington, Ind. His article, "New Medicare Payment Plan Will Have Major Effect on Hospitals." explained to Daviess County readers what the changes are and how they might affect hospital health care delivery in the future

Curt, a native of Loogootee, is a 1971 graduate of Indiana University. After serving four years in the Navy as a public affairs officer, he began his newspaper career with the Washington, Ind., Times-Herald: he later became editor of the Linton, Ind., Daily Citizen. He founded the Tri-County News in 1981.

### Jane Stegemiller Print (Series)

Jane Stegemiller, medical/health reporter for The Indianapolis News since 1981, received the ISMA award for her informative series on "Health Care for the Poor." Her series of 10 articles published over five days was written after interviews with 52 people during five months of research.

The series provided a detailed look at the history of the nation's health aid programs, and a careful examination of the current debate over who is responsible for the poor and how to finance their health care. Also examined were the local and national roles of government, medical care providers and individual responsibility.

This is the third consecutive year that Jane has won an ISMA journalism award. Last year she was cited for her comprehensive series, "The High Cost of Health Care," and in 1982 she received the award for a single story on hypertension.

Jane, whose hometown is Indianapolis, was graduated from DePauw University summa cum laude in 1979 with a degree in English literature. She has previously won journalism awards from United Press International, the National Hearing Association and the American Lung Association.

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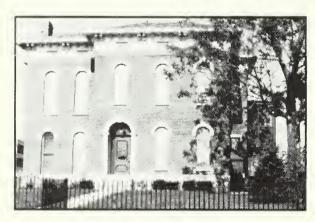
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Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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References: 1. Kales J et al. Clin Pharmacol Ther 12:691-697, Jul-Aug 1971. 2. Kales A et al. Clin Pharmacol Ther 18:356-363, Sep 1975 3. Kales A et al. Clin Pharmacol Ther 19:576-583, May 1976 4. Kales A et al. Clin Pharmacol Ther 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR. J Am Genatr Soc 27:541-546, Dec 1979 6. Kales A, Kales JD. J Clin Pharmacol J. Jan. 130-150, Apr 1983. 7. Greenblatt DJ, Allen MD, Shader RI. Clin Pharmacol Ther 21:355-361, Mar 1977. 8. Zimmerman AM: Curr Ther Res 13:18-22, Jan 1971. 9. Amrein R et al. Drugs Exp Clin Res 9(1) 85-99, 1983. 10. Monti JM. Methods Find Exp Clin Pharmacol 3:303-326, May 1981. 11. Greenblatt DJ et al. Sleep 5(Suppl 1):518-S27, 1982. 12. Kales A et al. Pharmacology 26:121-137, 1983.

DALMANE® ® flurazepam HCI/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCI; pregnancy. Benzodiazepines may cause tetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/ or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heart-burn, upset stomach, nausea, vomiting, diarrhea, constipation, Gl pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter laste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined. **Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCI.



DOCUMENTED IN THE SLEEP LABORATORY 1-5.

**PROVEN IN** THE PATIENT'S HOME



FOR A COMPLETE NIGHT'S SLEEP DALMANE (V)

flurazepam HCl/Roche

STANDS APART

15 MG/30 MG CAPS ILES

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